A Research Report to Meet the Requirements of the Master of Medicine in Psychiatry at the University of Cape Town

# A review of cannabis use among adolescents presenting to a tertiary psychiatric unit in Cape Town, South Africa, before and after the high court ruling in 2017 to decriminalize cannabis.

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## Declaration Page

I, Dr Michelle Swartz, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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This work had not been published prior to the registration for the MMed degree.

Signature: Signed by candidate

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# Glossary of Terms

1. Adolescence

Adolescence is understood as the period between childhood and adulthood (Arain et al, 2013). Commonly used definitions include:

- World Health Organization (WHO): Adolescence is defined as the years between the ages of 10 – 19 [4]. WHO divides adolescence into younger (10 – 14 years) and older (15 - 19 years). Statistics South Africa aligns with this definition.
- The World drug report 2018 (WDR): Divides adolescence into early (12-14 years) and late (15 – 17 years)
- This study used the ages of 13 to 18 as the age of adolescents to accommodate for the admission criteria of the unit that the research was conducted in.

2. Youth

The United Nations describes the term youth for people between the ages of 15 to 24 (United Nations 2013). In South Africa, however, youth is defined as all those between the ages of 15 to 35 years.[6]

3. Puberty

Puberty is a developmental period whereby the process of sexual maturation occurs (Dahl 2004). This results in physical and biological changes which includes increased growth, changes in fat and muscle composition, breast, genital and secondary sex characteristic development.[36]

4. Mental health

“Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” .[1]

5. Mental disorder

“A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.”[49]

6. Drug (psychoactive)

“Psychoactive drugs are substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions. Psychoactive drugs belong to a broader category of psychoactive substances that include also alcohol and nicotine.”[55]

7. Substance or drug use

The use of controlled psychoactive substances for non-medical and non-scientific purposes, unless otherwise specified.[1] For the purposes of this study, cannabis use can be defined as current use, recent use or lifetime use.

8. Substance or drug use disorder

“A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance.”[49]

# Abstract

Prepared for submission to the South African Journal of Psychiatry (SAJP)

## Background:

Cannabis is the most widely used substance worldwide and its use is much higher amongst adolescents. However, adolescents are at higher risk of negative sequelae secondary to this use, including poorer developmental outcomes and the possible development of mental disorders. On 31 March 2017, the South African High Court ruled that cannabis use by an adult in a private dwelling should be decriminalized.

## Aim

The aim of this study is to determine the clinical profile of adolescents who use cannabis, that present to a tertiary hospital in Cape Town, South Africa, before and after the high court ruling in 2017.

## Setting

The study was conducted reviewing folders of adolescents admitted at Groote Schuur Hospital (GSH) in the Emergency Psychiatric Unit, Ward C23 in Cape Town, South Africa.

## Methods

This study was a retrospective folder review of adolescents admitted from April 2015 to March 2019.

## Results

The study included 266 participants and the total number of adolescents using cannabis admitted during the study period was 116. Cannabis use was the most commonly used substance in the study, with increased use seen post-ruling (n = 75; 65%). The most common frequency of cannabis use reported was daily use (n = 43; 57%). When comparing psychiatric diagnoses between cannabis users and non-cannabis users**,** a significantly higher proportion of patients who used cannabis pre-ruling had psychotic disorder ($p < 0.001$) and substance use disorder ($p = 0.01$). Post–ruling, the significance

was $p < 0.001$ for psychotic and substance use disorders. The most common DSM-5 diagnoses in cannabis users pre-ruling were psychotic disorders (n = 27; 65.9%); post-ruling, it was psychotic disorders (n = 36; 48%) and trauma and stressor-related disorders (n = 31; 41.3%).

## Conclusion

The study showed an increasing prevalence of cannabis use in adolescents admitted with mental illness after the high court ruling in 2017. This study also demonstrates that adolescents remain a vulnerable population to the effects of cannabis. This highlights the need for more focused adolescent interventions and services.

## Keywords

Cannabis; adolescents; mental illness; high court ruling; pre-ruling; post-ruling

# Publication ready manuscript

## Introduction

Cannabis is the most widely used drug in the world and the overall estimated number of users has increase in comparison to previous years.[1] In 2021 cannabis users comprised an estimated 219 million of the global population.[56] Surveys completed in the general population indicates that drug use is much higher amongst adolescents and youth.[3] The cannabis use perception index shows that countries in Africa fall into the top two regions, with the greatest increase in cannabis use.[1] Cannabis has become more socially accepted, thought to be harmless and with its changing legal status it allows for more widespread exposure.[10,12] Cannabis has become more potent over the past few decades with an increasing THC percentage.[58] Despite this trend, over the same time period, there has been a significant decline in the percentage of adolescents who consider regular cannabis use to be harmful.[58] Not everyone who uses cannabis will experience long-term adverse outcomes, however, the risks of cannabis use are highest in certain groups including people with pre-existing mental disorders and adolescents.[12]

Significant neurodevelopmental changes occur during adolescence which itself is associated with an increase in risk-taking, reckless behaviour and sensation-seeking making adolescents particularly vulnerable to brain insults.[19] Factors which increase the risk of developing a substance use disorder (SUD) includes socioeconomic inequalities, poverty, limited education and marginalization which are factors that many adolescents in South Africa are exposed to.[3] In South Africa, cannabis is the most commonly used drug with initiation reported as early as 11 years old.[10] Ongoing cannabis use during adolescence can result in long-term changes in brain function that can adversely impact educational, professional, and social achievements.[12]

According to the World Health Organization, mental health conditions make up 16% of the global burden of disease and injury in adolescents.[4] Epidemiological studies which were done in low-middle and high-income countries (LMICs - HICs) showed that nearly 1 in 5 children to adolescents suffer from a mental health disorder.[17] In South Africa, factors which increase vulnerability to mental health disorders include exposure to

violence, HIV infection and substance use.[17] The risk of mental illness is further increased in environments with poor social support and particularly in LMICs countries with socio-economic inequalities, like South Africa.[50] Social support includes family support and community connection which is significantly associated with mental health problems in these adolescents from vulnerable environments.[16] Poor mental health has a strong association with other health and development concerns in youth which includes substance abuse, violence and lower educational achievements.[40]

The prevalence of cannabis use in adolescents with mental illness is high globally and in South Africa.[7] An early age of initiation of cannabis together with frequent/heavy use is a risk for psychopathology later on.[38,39] The exposure to cannabis during adolescence increases the risk for the development of psychosis in later life and this risk is dose related.[14,51] Adolescent dual-diagnosis (psychiatric disorder with co-morbid SUD) has multiple negative implications on social functioning, physical injury, sexual risk behaviour and the use of other illicit substances.[45-47] A SUD negatively influences the course of mental illness and is often an indicator of poor treatment outcome.[41,48] A local study in Durban in 2017, which looked at substance use in adolescents with mental illness, found that more than a third of the adolescents used substances.[48] This highlighted the need for urgent intervention in this vulnerable population.[48]

On 31 March 2017, the High Court of South Africa ruled that cannabis use by an adult in a private dwelling where possession, purchase and cultivation are for personal consumption should be decriminalized as it was inconsistent with the Constitution of South Africa.[11] This ruling did not include adolescents in its judgement.

Changes in cannabis legislation can influence individual and population level initiation, frequency and quantity of use and lead to the progression of cannabis use disorder and its sequelae in vulnerable groups, which includes adolescents. It is, therefore, important that legislative changes include policies which offer specific protection targeting adolescents.[13] Legislation in other countries has focused on protecting vulnerable individuals, including adolescents, such as Canada. One of the aims of the Cannabis Act is to keep cannabis out of the hands of the youth. The Act has several measures that help prevent youth from accessing cannabis.[53] This is important because targeted

interventions could minimize the harms associated with cannabis in this vulnerable age group. What is needed is more programs on substance use prevention focused on adolescents to increase awareness of the potential harms associated with cannabis use. In addition, screening of adolescents for SUD and once identified, to provide early interventions to improve outcomes.[7]

This study reviewed cannabis use and the clinical profile of hospitalized adolescents before and after the legislative changes in South Africa. The clinical setting was chosen for the study to identify those adolescents with a mental illness and cannabis use. This clinical data is important in understanding the needs of adolescents receiving care in the Groote Schuur Hospital psychiatry service, identifying those adolescents with a dual diagnosis and allowing for targeted substance intervention strategies for adolescents accessing this service.

## Hypothesis

It is hypothesized that, subsequent to the high court ruling in 2017, there would be an increase cannabis use post-ruling with an increase in substance related diagnoses.

## Aim

The aim of this study is to determine the clinical profile of adolescents who use cannabis, that present to a tertiary hospital in Cape Town, South Africa, before and after the high court ruling in 2017.

# Research methods and design

## Study design

A retrospective descriptive cross-sectional folder review was used in this investigation.

## Study Setting

The study was conducted reviewing the folders of adolescents admitted at Groote Schuur Hospital (GSH) in the Emergency Psychiatric Unit, Ward C23 in Cape Town, South Africa. The Ward provides a specialized service for patients who require urgent psychiatric evaluation and management. The in-patient unit can accommodate up to 16 patients at a time which includes adolescent, adult and geriatric patients.

These patients are admitted under the Mental Health Care Act for a 72-hour observation period. Patients who require further care after 72 hours are referred to the relevant allied psychiatric hospitals.

## Study participants

The folders of all adolescents admitted from April 2015 to March 2019 was included in the study. These adolescents were admitted into a tertiary ward with a wide variety of Mental disorders with or without co-occurring substance use. The ages of adolescents included in the study was 13 to 18 years to accommodate for the admission criteria of the unit. All adult and geriatric patients admitted into the tertiary ward during April 2015 to March 2019 were excluded from the study.

## Data collection

The following information was extracted from the folders and entered into a database:

1. Socio-demographic details including age, sex, and education
2. Substance history including cannabis, methamphetamines, alcohol and other
3. Psychiatric presentations including admission/s, discharge and referral
4. Psychiatric diagnosis on discharge/ transfer
5. Co-morbid medical conditions
6. Stressors and social issues
7. Family history of substance abuse or psychiatric history

### Data Analysis

The statistical package SPSS Version 27 was used to analyze the data. In order to describe the socio-demographic and clinical characteristics of adolescents using cannabis presenting to the unit, descriptive statistics were generated in the form of proportions (for categorical variables) and of means and standard deviations (for continuous variables). Comparative statistics was used in the form of Chi square tests or Fishers Exact tests where appropriate compared outcome variables pre- and post-ruling. Psychiatric diagnoses and stressors were associated with cannabis use using chi square tests. Since all data is categorical, normality does not apply.

### Ethical Considerations

Ethical approval for this study was obtained from the Human Research Ethics Committee (HREC 398/2021) at the University Of Cape Town Faculty Of Health Sciences. Permission was granted from Groote Schuur Hospital to conduct this study.

Patients were not interviewed by the researcher and data collection was completed via folder review. Confidentiality was ensured by removing non-essential identifying information (names, initials, and hospital numbers) and the data was collected and stored using assigned research numbers. Data was saved on a password-protected excel workbook on a password-protected device.

## Results

The study period was divided into the pre-ruling period from April 2015 to March 2017 - which was before the Western Cape High Court ruling that cannabis use for personal consumption should be decriminalized;[11] and the post-ruling from April 2017 to March 2019.

The total number of adolescents admitted during the study period was 266. Of these, 40,5% (n = 108) of participants were admitted during the pre-ruling period and 59,4% (n = 158) were admitted during the post-ruling period. There was a significant increase in the number of females admitted post-ruling. The majority of the admissions were first time admissions (n = 199; 74,8% overall) with 86,1% pre-ruling and 67,1% post-ruling.

The demographic characteristics of the sample are reported in table 1. The majority of admissions were between the age range 15–16-years pre- (n = 49; 45,3%) and post- (n = 67; 42,2%) ruling. Most adolescents (n = 182; 68%) were still attending school with 59.2% of participants in school pre-ruling and 74.7% post-ruling A small number of adolescents, 3% (n = 7), had completed school.

**Table 1. Demographic characteristics**

| | **Pre-ruling N=108(40.5%)** | **Post ruling N=158(59.4%)** |
|---|---|---|
| **Sex, n (%)** | | |
| Male | M= 73(67,6) | M= 67(42,4) |
| Female | F= 35 (32,4) | F= 91(57,6) |
| **Age, years (mean (SD))** | | |
| 13-14 | 14(13) | 31(19,6) |
| 15-16 | 49 (45,3) | 67 (42,4) |
| 17-18 | 45 (41,7) | 60 (40) |
| **Highest level of education** | | |
| Still in school | 64 (59,2) | 118(74,7) |
| Dropped out | 28(26) | 35(22,1) |
| Completed | 2(1,8) | 5(3,2) |
| Data unavailable | 14(13) | 0 |
| **Number of admissions** | | |
| First presentation | 93(86,1) | 106(67,1) |
| 2 or more | 15(13,9) | 52(32,9) |

Where family history data was available, the majority of patients (n = 126; 65%) had no history of psychiatric or substance use diagnoses; conversely, 17% (n = 32) had a family history of substance use problems. Fourteen percent of the sample (n = 27) had a family history of psychiatric diagnosis while 5% (n = 9) had a family history of both. For 28,1% (n = 72) of patients no data for family history was available.

Where medical history was available, (n = 259) the majority (n = 216; 83%) had no comorbid conditions and a minority of patients (n = 19; 7%) had a history of epilepsy/head injury. For 2,6% (n = 7) of patients no data for medical history was available.

Table 2 presents the substance use of the participants' pre and post ruling. The total number of patients using cannabis who were admitted during the study period was 116; of which 35% (n = 41) used pre-ruling while 65% (n = 75) used post-ruling. Where data was available for age of onset of cannabis use (n = 76) the majority were between 13-18 years of age (n = 54; 71%), with 57% pre-ruling (n = 16) and 79% (n = 38) post-ruling. Overall, just under one third were below the age of 12 (n = 22; 28,9%). When looking at school-going adolescents with concurrent cannabis use, 51.22% (n = 21) of participants were in school pre-ruling and 68% (n = 51) post-ruling.

**Table 2. Substance Use**

| | **Pre-ruling N = 90, (%)** | **Post-ruling N = 152, (%)** |
|---|---|---|
| **Substance use** | 52 (57.8) | 91 (59.9) |
| Cannabis | 41 (45.6) | 75 (49.3) |
| Methamphetamine | 20 (22.2) | 17 (11.2) |
| Alcohol | 18 (20) | 45 (29.6) |
| Methaqualone | 5 (5.6) | 5 (3.3) |
| Nicotine | 15 (16.7) | 37 (24.3) |
| Other | 1 (1.1) | 5 (3.3) |

| **Cannabis use** | **Pre-ruling N=41, (%)** | **Post-ruling N =75, (%)** |
|---|---|---|
| **Age of onset, years** | | |
| 12 and below | 12(29,3) | 10(13,3) |
| 13-18 | 16(39) | 38(50,7) |
| Data unavailable | 13(31,7) | 27(36) |
| **Frequency** | | |
| Daily | 12(29,3) | 31(41,3) |
| 2-3 x per week | 5(12,2) | 5 (6,7%) |
| Weekends | 5(12,2) | 9(12) |
| Monthly | 1(2,4) | 4(5,4) |
| Once off | 2(4,9) | 1(1,3) |
| Data unavailable | 16(39) | 25(33,3) |
| **Sex** | | |
| Male | 35(85,4) | 46(61,3) |
| Female | 6(14,6) | 29(38,7) |

Data was only available for frequency of cannabis use in 75 patients (see Figure 1). Overall, the majority used cannabis daily (n = 43; 57%) with forty eight percent (n = 12) pre-ruling and sixty two percent (n = 31) post-ruling. A minority of patients had documented urine toxicology results in their folders.

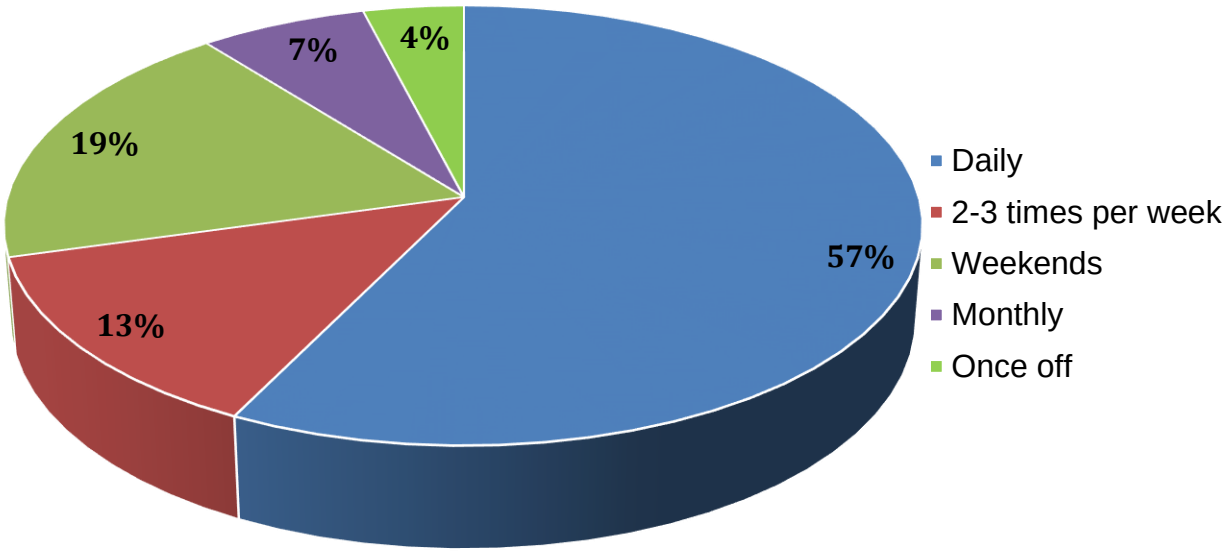


**Figure 1: Frequency of Cannabis Use Overall**

## DSM 5 psychiatric diagnoses and stressors

The most frequent psychiatric diagnosis was trauma and stressor-related disorders (n= 130; 48,9%) followed by major depressive disorders (n=105; 39,5%) and psychotic disorders (n=88; 33,1%). Bipolar disorder was diagnosed in 6% (n=16) and anxiety disorders in 3% (n=7) of patients.

Fifty percent (n=113) of the sample had experienced family conflict and 27% (n=61) experienced trauma. Twenty two percent of the sample (n=50) reported no stressors. Other stressors included bullying, sexual identity, conflict with friends and academic stress.

## Statistical Analyses

### Pre-ruling

When comparing psychiatric diagnoses between those who used cannabis and those who did not**,** a significantly higher proportion of patients who used cannabis had psychotic disorder ($p < 0.001$) and substance use disorder ($p = 0.01$). There were no other significant differences (see Table 3). Psychotic disorders (n = 27; 65.9%) were the most frequent psychiatric diagnosis in cannabis users, whereas, in non-cannabis users, depressive disorders (n = 20; 40.8%) and trauma and stressor-related disorders (n = 21; 42.9%) were the most common diagnoses.

There were no significant differences between those who used cannabis and those who did not use it in terms of stressors experienced (see Table 3). In both cannabis users and non-users, the most frequent stressor experienced was family conflict (51.3% and 48.7%), and the least common stressor experienced was bereavement (11.8% and 7.5).

### Post-ruling

When comparing psychiatric diagnoses between those who used cannabis and those who did not, a significantly higher proportion of patients who used cannabis had psychotic disorder and substance use disorder ($p < 0.001$). A significantly higher proportion of patients who did not use cannabis had depressive disorder ($p = 0.013$). Psychotic disorders (n = 36; 48%) and trauma and stressor-related disorders (n = 31; 41.3%) were the most frequent psychiatric diagnoses in cannabis users, whereas, in non-cannabis users, depressive disorders (n = 40; 51.9%) and trauma and stressor-related disorders (n = 29; 37.7%) were the most common diagnoses.

A significantly higher proportion of patients who used cannabis post-ruling reported experiencing trauma ($p = 0.013$) and family conflict ($p = < 0.001$). A significantly higher proportion of patients who did not use cannabis reported experiencing any stressors (p

= 0.005). In both cannabis users and non-users, the most frequent stressor experienced was family conflict (69.9% and 30.3%), and the least common stressor experienced was bereavement (17.8% and 11.8%) (see Table 3).

**Table 3. Psychiatric diagnoses and stressors in cannabis and non-cannabis users: pre- and post-ruling admissions**

| | **Pre-ruling Cannabis use** | | **Test Statistics** | **Post-ruling Cannabis use** | | ***Test Statistics*** |
|---|---|---|---|---|---|---|
| | **Yes** | **No** | | **Yes** | **No** | |
| | ***n* = 41, (%)** | ***n* = 49, (%)** | ***p*** | ***n* = 75, (%)** | ***n* = 77, (%)** | ***p*** |
| **Psychiatric diagnosis** | | | | | | |
| Psychotic disorders | **27 (65.9)** | 13 (26.5) | **< 0.001**** | **36 (48)** | 9 (11.7) | **< 0.001**** |
| Bipolar disorders | 0 | 3 (6.1) | 0.248 | 6 (8) | 7 (9.1) | 0.810 |
| Depressive disorders | 9 (22) | **20 (40.8)** | 0.056 | 24 (32) | **40 (51.9)** | **0.013*** |
| Anxiety disorders | 0 | 2 (4.1) | 0.498 | 1 (1.3) | 2 (2.6) | 1.00 |
| Trauma and stressor-related disorders | 13 (31.7) | **21 (42.9)** | 0.277 | **31 (41.3)** | **29 (37.7)** | 0.643 |
| Substance abuse disorders | 8 (19.5) | 1 (2) | **0.010*** | 25 (33.3) | 0 | **< 0.001**** |
| Other | 1 (2.4) | 3 (6.1) | 0.623 | 6 (8) | 9 (11.7) | 0.446 |
| | **Pre-ruling Cannabis use** | | | **Post-ruling Cannabis use** | | |
| | **Yes** | **No** | | **Yes** | **No** | |
| | ***n* = 34, (%)** | ***n* = 40, (%)** | ***p*** | ***n* = 73, (%)** | ***n* = 76, (%)** | ***p*** |
| **Stressors** | | | | | | |
| Trauma | 6 (17.6) | 10 (25) | 0.444 | 29 (39.7) | 16 (21.1) | **0.013*** |
| Family Conflict | **20 (51.3)** | **19 (48.7)** | 0.331 | **51 (69.9)** | **23 (30.3)** | **< 0.001**** |
| Bereavement | 4 (11.8) | 3 (7.5) | 0.696 | 13 (17.8) | 9 (11.8) | 0.305 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Single Parent | 11 (32.4) | 9 (22.5) | 0.342 | 16 (21.9) | 19 (25) | 0.657 |
| Other | 7 (20.6) | 5 (12.5) | 0.347 | 18 (24.7) | 12 (15.8) | 0.177 |
| None | 8 (23.5) | 9 (22.5) | 0.916 | 9 (12.3) | 24 (31.6) | **0.005*** |

*Note.* [a]Fisher's exact test performed. *$p < 0.05$. **$p < 0.001$.

In summary, the majority of admissions were index presentations between the age range 15-16 years pre- (n = 49; 45,3%) and post- (n = 67; 42,2%) ruling. An increase in the number of admissions seen post-ruling (n = 158; 59,4%). In addition, the number of female admissions into the unit increased (n = 91; 57,6%) compared to pre-ruling, where the majority was male (n = 73; 67,6%). Where family history data was available, most patients had no history of psychiatric or substance use diagnoses (n = 126; 65%). Cannabis use was the most commonly used substance in the study, with increased use seen post-ruling (n=75; 49.3%). The most common frequency of cannabis use reported was daily use (n = 43; 57%). The most common DSM-5 diagnoses in cannabis users pre-ruling were psychotic disorders (n = 27; 65.9%)and post-ruling psychotic disorders (n = 36; 48%) and trauma and stressor-related disorders (n = 31; 41.3%).

## Discussion

This study was completed in a single tertiary-level hospital in the Western Cape and included 266 participants. This study reports a high proportion of school-going adolescents, with 59.2% of participants in school pre-ruling and 74.7% post-ruling. Of those school-going adolescents with concurrent cannabis use, 51.22% of participants were in school pre-ruling and 68% post-ruling. This differed from findings in a non-clinical study of Western Cape schools in 2011 which showed 23,6% of adolescents reporting cannabis use.[20]

Most of the admissions were index presentations and there was an increase in the number of adolescents admitted into the unit post-ruling. The possible reasons for ongoing increases in admission rates may include societal and policy changes in a growing population.[28] The society surrounding adolescents has changed from previous

years in a way that places more demands on them, making coping with those demands harder than before, eventually leading to seeking psychiatric treatment or being referred.[34,35] In the South African context, societal stressors such as high rates of crime, violence, poverty and substance abuse are factors resulting in psychiatric morbidity in children and adolescents.[33] It is thought that a redefining of normal adolescent development has taken place, which was viewed as just behavioural problems to now being recognized as psychiatric disorders. Another reason for an increased need for psychiatric inpatient care may be inadequately resourced outpatient and preventive services in adolescents.[28]

The most commonly reported substances used in the study pre-ruling were cannabis, methamphetamines and alcohol, however, post-ruling it was cannabis, alcohol and nicotine. This data differs from a 2011 non-clinical study in Western Cape schools which showed that cannabis was the third most reported substance after tobacco and alcohol.[20] Factors which can account for this difference in findings is that their sample was in a non-clinical setting. The population in our sample represent adolescents with psychiatric symptoms that required admission and thus the pattern of substance use may be different in this population. This is in keeping with a review of illicit drug use in South Africa, where the estimated cannabis use percentage in otherwise healthy adolescents was much lower than the rates of cannabis use found in the mentally ill population.[7,27] More recent data from The South African Community Epidemiology Network on Drug Use (SACENDU) update of 2022 which looks at treatment data, showed that across the majority of sites in South Africa, most people under the age of 20 years reported that cannabis was their primary drug used.[9] Another contributor could be increased cannabis use over time in the adolescent population. This was seen in a Canadian study looking at trends in youth cannabis use across cannabis legalisation.[32] In a cross-sectional analysis, it showed that cannabis ever-use was significantly higher in the year after legalisation compared to the year in which it took place which indicates an increase over time.[32] The change in substance use trends that was seen in pre- vs post-ruling is also in keeping with international trends where exception for nicotine and alcohol, cannabis is the most commonly used drug in young people.[1] The reasons for

this include the perceived ease of availability together with the perceptions of low risk of harm in comparison to other substances.[1]

In our study, both pre- and post-ruling, cannabis was the most reported substance used. This could be attributed to the fact that poor mental health is associated with substance use and substance use in adolescence serving as a risk factor for mental illness. In addition, the prevalence of cannabis use in adolescents with mental illness is high globally and in South Africa.[7] In a local study in Durban, the lifetime use of cannabis reported in adolescents admitted to a psychiatric unit was 68,1%.[29] Our study also shows a 3,7% increase in adolescents who smoked cannabis when comparing data pre- and post-ruling, which indicates an increased prevalence of cannabis use. This is in keeping with the World Drug Report of 2023, which states that the overall estimated number of annual cannabis users has increased by 21% over the past decade.[56] The increase can be explained by the attitudes about cannabis use continuing to move toward greater acceptance.[31] In our study, urine toxicology results were not reported on, due to a minority being documented. Drug testing in adolescents is important, as they may not be forthcoming and it may be useful when the history is negative in the context of clinical signs and symptoms suggesting substance use.[54]

In a small South African qualitative study looking at the socio-ecological influences of adolescent cannabis use initiation, the three main areas of influence identified were personal characteristics, micro and macro level influences. [26] These included curiosity, negative school climate, peer pressure, parental or sibling cannabis use, poverty, presence of cannabis in communities, child labour and breakdown in communal restrictions against cannabis use.[26]

There was a gender difference in our study pre- and post-ruling, with 67.6% of participants being male pre-ruling and 57.7% being female post-ruling. In addition, the proportion of females using cannabis increased post-ruling. A possible reason for these differences seen post-ruling is that the gender divide of cannabis use is reducing in some regions according to the World Drug Report of 2023.[56] Despite this difference, both pre- and post-ruling, the majority of the adolescents who used cannabis were male. In all 3 South African Youth Risk Behaviour Surveys', cannabis use was higher in

males than females.[21-23] Of note, in the small qualitative study referred to in the previous paragraph, all the participants included were male between the ages of 14-19 years.[26] A possible reason why more males are found to use cannabis may be adherence to dominant male norms or male typicality. This, was found to be associated with higher rates of substance use and dependence, however, how gender is expressed through cannabis use is complex and ever-evolving.[52] This gender difference was also found in the 2011 study in Western Cape schools and that of those learners who smoked cannabis, 14% reported initiation before to age 13. In our study, the age of onset differed and was 28,9% for ages 12 and below, however, this data was not available for all study participants.

Regarding DSM–5 diagnoses, findings showed pre- and post-ruling that major depressive disorders and trauma and stressor-related disorders were the most common diagnoses in non-cannabis users. This is in keeping with the World Health Organization, where depression was found to be the most common cause of illness and disability in adolescents, with self-harm part of the top 10 causes.[5] Depression and post-traumatic stress were found to be common in adolescents from poorer socio-economic conditions.[16] The risk of mental illness is increased in environments with poor social support and particularly in LMICs countries with socio-economic inequalities, like South Africa. In the South African context, factors which further increase vulnerability to mental health disorders include exposure to violence, HIV, infection and substance use.[16, 17]

Trauma was experienced as a stressor in cannabis users both pre- and post-ruling. However, there was a significantly higher proportion of patients who used cannabis post-ruling that reported experiencing trauma which included physical, verbal, sexual and neglect. This is in keeping with an association that was found between childhood abuse and an increased alcohol/drug problem and drug use coping motives in a Cape Town study of school-going adolescents.[18] The types of childhood abuse included emotional, physical and sexual abuse.[18] The most common stressor found in our study participants pre- and post-ruling was family conflict in both cannabis and non-cannabis users. The most significant finding was family conflict in those adolescents who used cannabis post-ruling. In addition to a higher proportion of patients experiencing trauma

as a stressor post-ruling, there was also a difference seen in our study in psychiatric diagnoses. Psychotic disorders were found to be the most common diagnosis pre-ruling, however, post-ruling psychosis and trauma and stressor-related disorders were most common. A possible explanation for this could be that in the study, the number of participants that used cannabis post-ruling was increased which resulted in the difference in findings. In an American study, higher rates of childhood trauma, lifetime trauma, and major life events were found in cannabis users when compared to non-users.[57] A possible explanation for why trauma-exposed individuals have high rates of cannabis use may be dysregulation of the endocannabinoid system.[57] Another possible explanation is that the proportion of females using cannabis increased post-ruling. According to the World drug report of 2018, women who experienced childhood adversity such as physical neglect, abuse or sexual abuse may use drugs to self-medicate. In addition, women with substance use disorders are reported to have high rates of post-traumatic stress disorder.[1]

There is increasing evidence that shows an association between adolescents who use cannabis regularly and having more severe and negative outcomes compared to those that use it during adulthood.[8,12] In our study, both pre- and post-ruling, a significantly higher proportion of patients who used cannabis had psychotic disorder and substance use disorder. Studies of psychosis have shown that certain individuals are more vulnerable to the effect of cannabis than others.[25] These include early age of initiation of cannabis, increased frequency of use and increased potency of cannabis used.[7] Where data was available for the frequency of cannabis use in our study, daily use was reported in more than half of the participants. Daily use of cannabis, especially high potency, drives the earlier age of onset of psychosis in cannabis users.[24]

## Limitations

There were several limitations to this study.

1) This was a retrospective folder review which is reliant on clinical notes which may be influenced by the interviewer's experience and training.

2) Not all patients had a urine toxicology test documented. These were requested in most adolescents admitted, but tests were not always available due to budget constraints. This is an important factor as in the majority of cases we were unable to confirm the substance history with a test. The timing of testing is also important as if these tests are not done on the day of admission it may result in a false negative when conducted later. This can influence the reliability and validity of the study.
3) This study was conducted in a single hospital in the Western Cape with a relatively small cohort of patients; therefore, generalizability to the greater adolescent population may be limited.

## Recommendations

Adolescents represent a vulnerable population requiring complex interventions. This study showed an increase in adolescent admissions together with an increase in adolescents that used cannabis after the 2017 Western Cape High court ruling.

The authors suggest the following recommendations that could help improve the management of adolescents with comorbid mental illnesses and substance use presenting for hospital care. These recommendations have been divided into unit specific, in relation to where the study was conducted, and general recommendations.

The unit specific recommendations include, firstly, the need for an adolescent admission booklet due to the increasing number of adolescent admissions and the specific clinical data, of note a detailed substance history, which is relevant to this vulnerable population to provide comprehensive care. Secondly, urine toxicology testing on admission is essential, to confirm the substance history with a test, as this may influence diagnoses and further management. Early detection and intervention of substance use in adolescents can reduce harm and improve outcomes. Thirdly, due to the increasing number of adolescents admitted into the unit, having adolescent groups focused on substance use prevention to increase awareness of the potential harms and promote mental health. This, however, is limited by the available resources and the unit providing

acute care for other populations including geriatrics patients. The recommendations above will assist in more accurately identifying the substance use problem faced by adolescents and thus will allow for the appropriate linkage to care on discharge or transfer. These recommendations may be applicable to other settings in the province and nationally.

The general recommendations include the need for dual diagnosis programs for adolescent patients with mental health and substance use disorders. This would assist in improving the prognosis and reduce the rates of re-hospitalisation. In resource-constrained settings, like South Africa, this service would be difficult to establish and requires strategic planning and budget allocation from the Department of Health. With cannabis use increasing among youth, strategies and interventions for reducing and preventing cannabis use is important in this group to reduce the health risks and disease burden. This would include health promotion and education programmes targeted at all adolescents.

## Conclusion

This study examined the clinical profile of adolescents admitted to a tertiary psychiatric unit in Western Cape before and after the 2017 high court ruling to better understand the prevalence of use of cannabis, sequela of use, factors influencing use and protective factors. This study demonstrates that adolescents remain a vulnerable population to the effects of cannabis with the increasing prevalence of cannabis use in adolescents admitted with mental illness. This study was limited by being in a single hospital, however, it highlighted the need for ongoing research in adolescents regarding their mental health burden and substance use, especially cannabis within the South African context in the light of the changing legislation. Additionally, this emphasizes the need for more focused adolescent interventions and services and the need for legislation aimed at protecting vulnerable individuals like adolescents.

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### Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

### Author contributions

All authors conceptualized the study. MS collected the data and wrote the final draft. LD and AL supervised the study and edited the article.


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The authors have nothing to disclose.


### Data availability

Data sharing and availability does not apply to this article as no new data were created or analyzed in this study.

### Disclaimer

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

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## Supervisor declaration

The journal publishing the paper is accredited by the Department of Higher Education and Training or it has been approved by the UCT Health Sciences Specialist Training Committee and:

- The candidate is the first author on the paper
- The candidate contributed the most to the paper
- The candidate developed the protocol and wrote the paper under supervision
- The candidate was involved in the analysis, presentation, and interpretation of results
- The other authors and their contributions to the paper are stated.

Signed:

Dr Lisa Dannatt

# Appendices

## Appendix I: High court ruling

IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE DIVISION, CAPE TOWN)

***Reportable***

CASE NO: 8760/2013

In the matter between:

| | |
|---|---|
| **GARETH PRINCE** | Applicant |
| and | |
| **MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT** | First Respondent |
| **MINISTER OF POLICE** | Second Respondent |
| **MINISTER OF HEALTH** | Third Respondent |
| **MINISTER OF TRADE AND INDUSTRY** | Fourth Respondent |
| **DIRECTORATE OF PUBLIC PROSECUTIONS** | Fifth Respondent |

CASE NO: 7295/2013

In the matter between:

| | |
|---|---|
| **JONATHAN DAVID RUBIN** | Plaintiff |
| and | |
| **NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS** | First Defendant |
| **MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT** | Second Defendant |
| **MINISTER OF HEALTH** | Third Defendant |
| **MINISTER OF SOCIAL DEVELOPMENT** | Fourth Defendant |
| **MINISTER OF INTERNATIONAL RELATIONS AND COOPERATION** | Fifth Defendant |
| **MINISTER OF TRADE AND INDUSTRY** | Sixth Defendant |

| | |
|---|---|
| **MINISTER OF POLICE** | Seventh Defendant |

**and**

4153/2012

**In the matter between:**

| | |
|---|---|
| **JEREMY DAVID ACTON** | First Plaintiff |
| **RAS MENELEK BAREND WENTZEL** | Second Plaintiff |
| **CARO LEONA HENNEGIN** | Third Plaintiff |

**and**

| | |
|---|---|
| **NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS** | First Defendant |
| **MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT** | Second Defendant |
| **MINISTER OF HEALTH** | Third Defendant |
| **MINISTER OF SOCIAL DEVELOPMENT** | Fourth Defendant |
| **MINISTER OF INTERNATIONAL RELATIONS AND COOPERATION** | Fifth Defendant |
| **MINISTER OF TRADE AND INDUSTRY** | Sixth Defendant |
| **MINISTER OF POLICE** | Seventh Defendant |

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**JUDGMENT: 31 March 2017**

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**DAVIS J**

**Introduction**

[1] In a constitutional democracy such as South Africa, a critical task which confronts courts is to demarcate the border between the terrain in which disputes lie in the province of the courts and those controversies which are better located on a

terrain belonging to the legislature and/or the executive. This problem is exacerbated by virtue of the fact that law inevitably underpins both the conduct of individual citizens and of the State. All forms of human interaction, either between individuals or between individuals in the State, are sourced in a law which permits, prohibits or circumscribes the relevant conduct whether the latter be positive or negative. See in particular W N Hohfeld *Fundamental Legal Conceptions* (1923).

[2] This case focuses upon this precise question; namely the extent to which laws that prohibit the use of cannabis and the possession, purchase of cultivation thereof for personal consumption exclusively are valid. The laws which are the subject of this dispute regulate the conduct of cannabis consumption even in the privacy of a home. This case thus asks whether the invalidity of the relevant legislative framework in terms of which these prohibitions are couched should be determined by courts or left for further legislative and/or executive consideration.

[3] The relief which is sought is not particularly easy to divine because the application brought before this Court has been made by individual applicants, whose application and papers reveal a lack of legal precision particularly in the framing of the relief sought. Initially Mr Acton brought an action, Mr Prince launched an application. Eventually the action brought by Mr Acton was consolidated with Mr Prince's application.

[4] Determined in the most coherent possible light, the dispute in terms of the relief sought can be divided into three categories, namely:

a) The applicants seek a declaration that the legislative provision against the use of cannabis and the possession, purchase and cultivation of cannabis for personal or communal consumption is invalid. Accordingly the following

provisions are impugned: ss 4 (b) and 5 (b) of the Drugs and Drug Trafficking Act 140 of 1992 ("the Drugs Act") read with part 3 of Schedule 2 to the Drugs Act insofar as it relates to "simple possession, cultivation, transportation and distribution of cannabis for personal communal consumption"; s 22 A (10) of the Medicines and Related Substances Control Act 101 of 1965 ("the Medicines Act") read with Schedule 8 (which should actually be Schedule 7) of the Medicines Act insofar as it relates to consumption of cannabis and; the legislative provision against the possession and use of cannabis by adults. Mr Acton also seeks a right to use cannabis for various other purposes including medicinal, economic, transportation and trade.

I should note that this prayer is framed in somewhat general terms, particularly in Mr Acton's particulars of claim which do not refer to any particular statutory provision. However the legislative target of applicants is clear from the papers, particularly Mr Prince's notice of motion.

b) Applicants seek a declaration of invalidity of the following provision, references to cannabis in s 21 of the Drugs Act which contains presumptions relating to the dealing in cannabis.[1]

---

[1] This section provides as follows:

(1) If in the prosecution of any person for an offence referred to-

(a) in section 13 (f) it is proved that the accused-

(i) was found in possession of dagga exceeding 115 grams;

(ii) was found in possession in or on any school grounds or within a distance of 100 metres from the confines of such school grounds of any dangerous dependence-producing substance; or

(iii) was found in possession of any undesirable dependence-producing substance, Other than dagga.

It shall be presumed, until the contrary is proved, that the accused dealt in such dagga or substance;

(b) in section 13(f) it is proved-

(i) that dagga plants of the existence of which plants the accused was aware or cold reasonable be expected to have been aware, were found on a particular day of cultivated land; and

It should be noted that s 21 (1) (a) (i) of the Drugs Act has been declared unconstitutional. See *S v Bhulwani; S v Gwadiso* 1996 (1) SA 388 (CC). Applicants also seek a declaration of invalidity of s 40(1)(h) of the Criminal Procedure Act 51 of (1977) ("the CPA") insofar as the latter refers to cannabis. Section 40 (1) (h) of the CPA empowers a peace officer without a warrant to arrest any person who is reasonably suspected of having committed an offence under any law and governing the making, supply, possession or conveyance of cannabis.

c) The applicants seek relief that, in the event that a declaration of invalidity is suspended, this court should make an order which would operate during the period of suspension preventing the arrest, detention and prosecution for use of, possession, cultivation and the transportation of small amounts of cannabis intended for personal use and a stay of all pending prosecutions and release from custody of persons who are in detention pursuant to such proceedings.

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(b) that the accused was on the particular day the owner, occupier, manager or person in charge of the said land.

it shall be presumed, until the contrary is proved, that the accused dealt in such dagga plants;

(c) in section 13(e) or (f) it is proved that the accused conveyed any drug, it shall be presumed, until the contrary is proved, that the accused dealt in such drug

[section 21(1)(c) was declared to be inconsistent with the Interim Constitution and, accordingly, of no force and effect – GN R585 in GG 21266 of 15 June 2000]

(d) in section 13(e) or (f) it is proved-

(i) that any drug was found on or in any animal, vehicle, vessel or aircraft; and

(ii) that the accused was on or in charge of, or that he accompanied, any such animal, vehicle, vessel or aircraft.

it shall be presumed, until the contrary is proved, that the accused dealt in such drug."

**The chronology of this application**

[5] Before proceeding to examine the key provisions which applicants seek to have declared invalid, it is necessary to outline the manner in which these proceedings before this court were conducted. When this matter was initially brought before this Court, only the individual applicants appeared against an experienced legal team representing respondents. As indicated, the relief as sought by applicants was couched in imprecise terms. The papers, as filed, made it even more difficult for this court, without a comprehensive legal debate from the competing parties to determine an issue of considerable social importance.

[6] It was apparent that, were the Court to be placed in the position to evaluate all of the arguments both in favour and against the relief sought as I have set it out, further assistance was required. For this reason, the chairperson of the Cape Bar Council was contacted by this Court with a request that member(s) of the Bar act as amicus curiae in this matter to ensure that independent but comprehensive legal analysis might be provided to ensure that the dispute could be fairly and fully ventilated before this Court. In addition, Professor Mark Shaw of the Centre of Criminology, Faculty of Law, University of Cape Town was contacted to provide an expert report, given that a considerable amount of the documentation filed by applicants proved to be of very little assistance in the determination of this case. I shall return later in this judgment to the legal admissibility of this evidence. Suffice to say at this stage that much of the voluminous documentation provided, in particular by Mr Acton, proved of little value to the determination of this application.

[7] Professor Shaw and his colleagues filed an affidavit, to which I shall refer presently. A further opportunity was then given to respondents to file further

expert reports that they deemed necessary in order to respond to Professor Shaw et al. This was also designed to provide them with an opportunity to address what the amicus curiae contended were shortcomings in their expert evidence. Respondents filed further affidavits the contents of which were produced, I shall refer presently. It was on this basis that the case was finally argued before this Court.

[8] The Court should record its considerable debt of gratitude to Mr Roux, Mr Paschke and Ms Foster who appeared as amici curiae at the request to the Court and whose meticulous research and argument proved to be extremely helpful. Similarly, this Court is indebted to Professor Mark Shaw, Dr Simon Howell, Dr Andrew Faull and Anine Kriegler who by way of an affidavit produced a report for this Court entitled "Balancing Harms in Cannabis policy for South Africa".

**The legislative framework**

[9] The key sections which are the subject of this dispute are sections 4 (b) and 5 (b) of the Drugs Act and s 22A of the Medicines Act. Section 4 (b) of the Drugs Act provides thus:

> No person shall use or have in his possession ....
>
> (b) any dangerous dependence-producing substance or any undesirable dependence-producing substance,
>
> unless-
>
> (i) he is a patient who has acquired or bought any such substance-

(aa) from a medical practitioner, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder; or

(bb) from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, dentist or practitioner,

and uses that substance for medicinal purposes under the care or treatment of the said medical practitioner, dentist or practitioner;

(ii) he has acquired or bought any such substance for medicinal purposes-

(aa) from a medical practitioner, veterinarian, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder;

(bb) from a pharmacists in terms of an oral instruction or a prescription in writing of such medical practitioner, veterinarian, dentist or practitioner; or

(cc) from a veterinary assistant or a veterinary nurse in terms of a prescription in writing of such veterinarian,

with the intent to administer that substance to a patient or animal under the care or treatment of the said medical practitioner, veterinarian, dentist or practitioner;

(iii) he is the Director-General: Welfare who has acquired or bought any such substance in accordance with the requirement of the Medicines Act or any regulation made thereunder;

(iv) he, she or it is a patient, medical practitioner, veterinarian, dentist, practitioner, nurse, midwife, nursing assistant, pharmacist, veterinary assistant, veterinary nurse, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter, or any other person contemplated in the Medicines Act or any regulation made thereunder, who or which has acquired, bought, imported, cultivated, collected or

manufactured, or uses or is in possession of, of intends to administer, supply, sell, transmit or export any such substance in accordance with the requirements or conditions of the said Act or regulation, or any permit issued to him, her or it under the said Act or regulation;

(v) he is an employee of a pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, imported or exported who has acquired, bought, imported, cultivated, collected or manufactured, or uses or is in possession of, or intends to supply, sell, transmit or export any such substance in the course of his employment and in accordance with the requirements or conditions of the Medicines Act or any regulation made thereunder, or any permit issued to such pharmacists, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter under the said Act or regulation, or

(vi) he has otherwise come into possession of any such substance in a lawful manner.

Section 5 (b) provides as follows:

No person shall deal in ...

(b) any dangerous dependence-producing substance or any undesirable dependence-producing substance,

unless-

(i) he has acquired or bought any such substance for medicinal purposes-

(aa) from a medical practitioner, veterinarian, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder;

(bb) from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, veterinarian, dentist or practitioner; or

(cc) from a veterinary assistant or veterinary nurse in terms of a prescription in writing of such veterinarian,

and administers that substance to a patient or animal under the care or treatment of the said medical practitioner, veterinarian, dentist or practitioner;

(ii) he is the Director–General: Welfare who acquires, buys or sells any such substance in accordance with the requirements of the Medicines Act or any regulation made thereunder;

(iii) he, she or it is a medical practitioner, veterinarian, dentist, practitioner, nurse, midwife, nursing assistant, pharmacist, veterinary assistant, veterinary nurse, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter, or any other person contemplated in the Medicines Act or any regulation made thereunder, who or which prescribes, administers, acquires, buys, transhipS, imports, cultivates, collects, manufactures, supplies, sells, transmits or exports any such substance in accordance with the requirements or conditions of the said Act or regulation, or any permit issued to him, her or it under the said Act or regulation; or

(iv) he is an employee of a pharmacists, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter who acquires, buys, transhipS, imports, cultivates, collects, manufactures, supplies, sells, transmits or exports any such substance in the course of his employment and in accordance with the requirements or conditions of the Medicines Act or any regulation made thereunder, or any permit issued to such pharmacists, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter under the said Act or Regulation."

[10] Cannabis is listed under Schedule 7 of the Medicines Control Council: Schedules. Section 22 A (9) (a) (i) of the Medicines Act prohibits the acquisition, use, possession, manufacture or supply of cannabis. Subsection (10) provides an overriding prohibition on the sale or administration of cannabis other than for medicinal business.

**The applicants cause of action**

[11] Reflective of the imprecision of applicants' papers, to which I have already made reference, applicants invoked a veritable constitutional laundry list to argue that the criminal prohibition of the use and possession of cannabis in their own homes and "properly designated places" was unconstitutional. In particular, they contended that, pursuant to the impugned legislation, fundamental rights such as equality dignity and freedom of religion were breached. However, the core of this case and thus the main challenge against the legislation, to which I have made reference, is to locate in the right to privacy. A further argument by applicants was then raised that the distinction between cannabis and other harmful substances, such as alcohol and tobacco is irrational and hence the limitation of the right to privacy was unjustifiable in terms of s 36(1) of the Republic of South Africa Constitution Act 108 of 1996 ("the Constitution"). So much is clear from the founding affidavit deposed to by Mr Prince (the first applicant).

**The question of *res judicata*: in limine argument**

[12] Before dealing with the merits of this application, respondents raised the doctrine of *res judicata* in that the issues which emerges in the present case had previously been disposed of by the Constitutional Court in *Prince v The President Cape law Society and others* 2002 (2) SA 794 (CC) (referred to in this dispute as Prince 2). In Prince 2, one of the present applicants, Prince, challenged the constitutionality of sections 4(a) and 4(b) of the Drugs Act together with s 22 A of the Medicines Act. He contended that they were in conflict with the Constitution, in particular that these provisions infringed, inter alia, his right to religious freedom contained in s 15 (1) of the Constitution.

[13] In Prince 2, argument was directed against the impugned provisions as being overbroad in that they prohibited the use of cannabis for all persons, regardless of the purpose of the use of cannabis. The inclusion of Rastafari, according to Prince, was unjustifiable in that the prohibition extended its scope to the possession or use which was required by members of the Rastasfari, as part of their religious practice. In the majority judgment, penned by Chaskalson CJ, Ackermann and Kriegler JJ, it was accepted that the legislation criminalising the use and possession of cannabis limited the religious rights of Rastafari under the Constitution and that what had to be decided was whether the limitation was justifiable in terms of s 36 of the Constitution (para 111). Significantly, in Prince 2 the applicant did not dispute that the legislation prohibiting the possession and use of cannabis by the general public served a legitimate government purpose. According to the majority 'he accepts that it does, but contends that his religion requires him to use cannabis and that out of respect for the religious rights of himself and other

Rastafari, the legislation ought to have made an exception in their favour permitting such use for religious purposes.' (para 113)

[14] The majority then went on to note:

> 'The unchallenged general prohibition in the disputed legislation against the possession or use of harmful drugs is directed in the first instance to cutting off the supply of such drugs to potential users. It seeks to address the harm caused by the drug problem by denying all possession of prohibited substances (other than for medical and research purposes) and not by seeking to penalise only the harmful use of such substances. This facilitates the enforcement of the legislation ... The State was not called upon to justify this method of controlling the use of harmful drugs. The validity of the general prohibition against both use and possession was accepted. The case the State was called upon to meet in this case was that in addition to the medical and research exemptions contained in the legislation provisions should also have been made for the use of cannabis for religious purposes by members of the Rastafari religion.' (para 116-117)

[15] In deciding Prince 2, the majority placed considerable emphasis on the difficulty confronting a litigant in seeking to be exempted for religious reasons from the provisions of a criminal law of general application, (para 129). In the view of the majority:

> 'There is no objective way in which a law enforcement official could distinguish between the use of cannabis for religious purposes and the use of cannabis for recreation. It would be even more difficult, if not impossible, to distinguish objectively between the possession of cannabis for the one or the other of the above purposes. Nor is there any objective way in which a law enforcement official

> could determine whether a person found in possession of cannabis who says that its possessed for religious purposes is genuine or not.' (para 130)

[16] Accordingly, the majority found that the granting of a limited exemption for the non-invasive religious use of cannabis, even under the control of a Rastafarian priest, was not a competent remedy on the evidence placed before the court (para 142). On this basis the majority dismissed the appeal.

[17] Significantly, in his minority judgment, Ngcobo J (as he then was), supported by three other judges which resulted in a 5:4 split in the Court, set out the terms under which he found the relevant legislation to be inconsistent with the Constitution because of its extensive prohibition of the use and possession of cannabis by Rastafari adherents for *bona fide* religious purposes.

> 'I accept that the goal of the impugned provisions is to prevent the abuse of dependent – producing drugs and trafficking in those drugs. I also accept that it is a legitimate goal. The question is whether the means to employ that goal are reasonable. In my view, they are not. The fundamental reason why they are not is because they are overbroad. They are ostensibly aimed at the use of dependence-producing drugs that are inherently harmful and trafficking in those drugs. But they are unreasonable in that they also target uses that have not been shown to pose a risk of harm or to be incapable of being subjected to strict regulation and control. The net they cast is so wide that uses that pose no risk of harm and that can effectively be regulated and subjected to government control like other dangerous drugs are hit by the prohibition.' (para 81)

[18] From this description of the judgments in Prince 2 it is clear that the Constitutional Court *did* not consider whether <u>any</u> prohibition as contained in ss 4 and 5 of the Drugs Act infringed the right to privacy. The case turned on a limited

question, namely an application for a limited exemption for religious reasons from the provisions of a criminal law of general application. As indicated, the majority found that the limitation of the right to religious freedom was justifiable because it would be impractical to administer a religious exemption without fundamentally undermining the general prohibition against possession. By contrast, the minority were of the view that a religious exemption could be granted without undermining the purpose of the prohibition. Indeed Ngcobo J made the limited scope of the dispute before the Court clear when he wrote:

> 'It is important to emphasise what this case is not about but what it is about. This case is not concerned with a broad challenge to the constitutionality of the prohibition on the use or possession of cannabis.' (para 31)

Ngcobo J went on to say:

> 'In this Court, as in the Courts below, this case was approached from the footing that the prohibition contained in the impugned provisions served a legitimate government interest. Indeed there was no suggestion either in the papers or in argument that the objective pursued by the prohibition was not laudable. The constitutional complaint before us is that the prohibition is constitutionally bad because it is overbroad. To put it differently, the complaint is that the legitimate government purpose served by the prohibition could be achieved by less restrictive means. It is that compliant, and it alone that we are called upon to consider.' (para 35) (my emphasis)

[19] The same approach was adopted in the majority judgment to the scope of the dispute:

> 'The primary issue in the appeal to this court was whether the SCA was correct in holding that the legislation was not inconsistent with the Constitution. In the SCA and again in this Court the challenge to the legislation was not against the

> criminalisation of the possession and use of cannabis. It was a limited one, namely whether the failure to provide an exemption in respect of the use of cannabis for religious purpose by Rastafari infringed their religious rights under the Constitution.' Para 94

[20] From these passages, it is clear that the doctrine of *res judicata* does not apply, in that Prince 2 did not decide the dispute presently before this court. It is fair to say that this dispute requires the court to deal precisely with that which was not an issue in Prince 2. To the extent that there is any doubt, Mr Prince in his founding affidavit brings clarity thereto by defining the issue before this Court as follows:

> 'The substantive questions in this matter are to what extent and in what way government may dictate, regulate or proscribe conduct considered to be harmful as well as what is the threshold the harm must cross in order for government to intervene. Can government legitimately dictate what people eat, drink or smoke in the confines of their own homes or in property designated places? Privacy concerns dictate and our constitution recognises that there should be an area of autonomy that precludes outsider intervention.'

It appears to me that this was the core of the case brought before this court, that is, whether the infringement of the right to privacy caused by the impugned legislation can be justified in terms of s 36 of the Constitution. Curiously in the light of the *in limine* challenge, in respondents' heads of argument applicants' case is summarised and described as 'a broader constitutional challenge to that confronted the Constitutional Court in Prince 2'. Mention is made of the applicants' attack that the current prohibition against cannabis violates the equality rights in terms of s 9 (2) of the Constitution in that cannabis users are treated differently in law from the users

of alcohol, tobacco and other foods substances. Further, it is contended that the applicants, particularly Mr Acton, claimed that they have medical rights to use cannabis and that cannabis is not only harmful but may be medically beneficial. It is also suggested that the case involves the argument that the prohibition impinges upon the rights to dignity, equality and freedom of cannabis user. Mention is made of the breach of the right of privacy, but only briefly which was unfortunate as it is this latter right, on the basis of Mr Prince's affidavit, which is central to his case. It is to that right that I must now turn.

**The right to privacy**

[21] Section 14 of the Constitution guarantees a right to privacy. In *Bernstein and others v Bester and others NNO* 1996 (2) SA 751 (CC) Ackermann J said:

> 'It seems to be a sensible approach to say that the scope of a person's privacy extends a fortiori only to these aspects in regard to which a legitimate expectation of privacy can be harboured.' (para 75)

Ackerman J went on to say:

> 'A very high level of protection is given to the individual's intimate personal sphere of life and the maintenance of its basic preconditions and there is a final untouchable sphere of human freedom that is beyond interference from any public authority. So much so that, in regard to this most intimate core of privacy, no justifiable limitation thereof can take place. But this most intimate core is narrowly construed. This inviolable core is left behind once an individual enters into relationships with persons outside this closest intimate sphere; the individuals' activities then acquire a social dimension and the right of privacy in this context becomes subject to limitation.' (para 77)

[22] It has become established law, insofar as privacy is concerned, that this right becomes more powerful and deserving of greater protection the more intimate the personal sphere of the life of a human being which comes into legal play. See, for example, *Investigating Directorate: Serious Economic Offenses and others v Hyundai Motor Distributors (Pty) Ltd and others In Re: Hyundai Motor Distributors (Pty) Limited and others v Smit NO and others* 2001 (1) SA 545 (CC) at para 183.

[23] There is a connection between an individual's right to privacy and the right to dignity which is protected in terms of s 10 of the Constitution. As the court noted in *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and another* 2014 (2) SA 168 (CC) at para 64: 'Privacy fosters human dignity insofar as it is premised on and protects an individual's entitlement to a "sphere of private intimacy and autonomy".' It follows from the animating idea of privacy that a right to make intimate decisions and to have one's personal autonomy protected is central to individual identity who is entitled to make decisions about these concerns without undue interference from the State. Indeed in *Case v Minister of Safety and Security* 1996 (3) SA 617 (CC) at para 91 Didcott J, in a case dealing with the question of the prohibition of the possession of pornography, went so far as to say:

> 'What erotic material I may choose to keep within the privacy of my home, and only for my personal use there, is nobody's business but mine. It is certainly not the business of society or the State.'

[24] There is also a link between privacy and the right to freedom. Further, privacy fosters and encourages the moral autonomy of citizens which is a central requirement of governance in a democracy. See D Solove *Understanding Privacy* (2008).

[25] The question which has to be asked in this case is whether the legislative framework, as I have outlined it, places limitations on this right to privacy. As noted earlier, in Prince 2 the Constitutional Court unanimously held that the impugned legislation limits the right of Rastafari to freedom of religion. So much was not in dispute between the majority and the minority judgments. If privacy, considered to be analysed as a continuum of rights which starts with an inviolable inner core moving from the private to the public realm where privacy is only remotely implicated by interference, it must follow that those who wish to partake of a small quantity of cannabis in the intimacy of their home do exercise a right to autonomy which, without clear justification, does not merit interference from the outside community or the State. The importance of the private domain of ordinary citizens was emphasised most recently in *Minister of Police and others v Kunjana* 2016 (9) BCLR 1237 (CC) at para 18.

[26] A similar conclusion must follow therefore with regard to the cultivation of a plant in the garden of one's home, if the plant was to be used exclusively for personal consumption. The adjective 'small' is of course difficult to define but is used to connote that the quantity must be exclusively for personal consumption. When 'quantity' is defined in legislation, the definition would need to pass constitutional muster in terms of a justifiable limitation of the right.

[27] I should again emphasise that this particular right and the breach thereof in the present circumstances was not contested in the written submissions of respondents and received a very tepid treatment, at best, during oral argument. For these reasons therefore, the present dispute must ultimately be determined in terms of the justification for the limitation of privacy as advanced by respondents.

**The limitation question**

[28] It is trite to remark that any right guaranteed Chapter 2 of the Constitution may be limited by a law of general application, to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account a series of factors which are set out in s 36 (1) of the Constitution. Thus:

> 'The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors including:
>
> (a) the nature of the right;
>
> (b) the importance of the purpose of the limitation;
>
> (c) the nature and extent of the limitation;
>
> (d) the relation between the limitation and its purpose; and
>
> (e) less restrictive means to achieve the purpose.'

[29] As this case turns on the determination of the factors set out in s 36 (1), the burden of justification now rests upon the State. As the Constitutional Court held in *Moise v Greater Germiston Transitional Local Council: Minister of Justice and Constitutional Development Intervening* 2001 (4) SA 491 (CC) at para 19:

> 'It is also no longer doubted that, once a limitation has been found to exist , the burden of justification under s 36(1) rests on the party asserting that the limitation is saved by the application of the provisions of the section. The weighing up exercise is ultimately concerned with the proportional assessment of competing interests but, to the extent that justification rests on factual and/or policy considerations, the party contending for justification must put such material before the court. ... If the government wishes to defend the particular enactment, it then has the opportunity –

> indeed an obligation – to do so. The obligation includes not only the submission of legal argument but the placing before court of the requisite factual material and policy considerations. Therefore, although the burden of justification under s 36 is no ordinary onus, failure by government to submit such data and argument may in appropriate cases tip the scales against it and result in the invalidation of the challenged enactment.'

[30] A further introductory remark before conducting the limitation analysis is appropriate. The limitation analysis should be conducted through the prism of a court's reading of the animating normative framework in terms of which Chapter 2 of the Constitution is to be located. In short, the provisions of Chapter 2 must be interpreted in the light of values which underlie an open and democratic society based on human dignity, equality and freedom. It follows that the rights contained in Chapter 2 were not designed to protect certain forms of behaviour which do not merit constitutional protection. Therefore there is a need to consider, at the first stage of the analysis, whether the relevant behaviour merits constitutional protection or, expressed differently whether what the court is dealing with is a genuine and serious violation of a constitutional right protected in Chapter 2. Once it is established that the infringement of a right is of so serious a nature that it is deserving of constitutional protection, a rigorous and careful process must be undertaken with respect to the justification for the impairment. See for a general discussion, Woolman et al Constitutional Law of South Africa (2nd ed) at Chapter 34 as well as Halton Cheadle in Cheadle et al South African Constitutional Law: the Bill of Rights (looseleaf) at Chapter 30.

[31] For reasons already articulated, the right in issue in this case, namely privacy not only passes the threshold test but is clearly deserving of constitutional protection, absent a clear justification to the contrary.

**Importance of the purpose of the limitation**

[32] The State is required under this heading to show that there is a substantial State interest which justifies the limitation. See *Magajane v Chairperson Northwest Gambling Board* 2006 (5) SA 250 (C) para 85. The history of cannabis (dagga) provides a significant context for this analysis. The use of cannabis was made illegal in 1928 prior thereto it had been traditionally used and indeed for centuries prior to the entry of criminal law. See King in *Grocott Mail* 10 June 2011 and more generally Hazel Crompton: *Dagga a Short History* (2015). Even in a standard criminal text book written by Professor Jonathan Burchell *Principles of Criminal Law* (4th ed) at 797 the following appears:

> 'South African substance abuse legislation involves an absolute prohibition on dealing in or possessing "dagga" (*Cannabis sativa*) (which has been widely cultivated for centuries in this country and used not only for recreational purposes but also as a folk medicine) cocaine, heroin and the like; a partial prohibition (through a licensing system) on the sale and consumption of intoxicating liquors containing alcohol, and a prohibition on the smoking and sale of tobacco (which contains nicotine).

[33] Much of this history is replete with the racism which has saturated South African society for more than three centuries, as is evidenced in the judgment of Marais et al JJ in *S v Nkosi* and others 1972 (2) SA 753 (T) at 762 A-B in which the following was said:

'(1) it is also relevant to consider the traditions and attitude of different groups of the population towards the use of a drug such as dagga;(2) it is general knowledge that some sections of the Bantu population have been accustomed for hundreds of years to the use of dagga, both as an intoxicant and in the belief that it has medicinal properties, and do not regard it with the same moral repugnance as do other sections of the population. Thus, in the standard work, Watt and Breyer-Brandwijk, *The Medicinal and Poisonous Plants of South Africa*, at p.35, one reads:

> "Cannabis sativa L. Cannabis indica, Indian hemp, hemp, hashish, ganjah, dagga, Xhosa umya, Suto matakwane, matokwane, matekwane, mmoana, is smoked as an intoxicant among South African natives. The Fingoes use the leaves as a snake-bite remedy, and the Xhosas as part of the treatment of bots in horses. The 'oil' from a dagga pipe has been used by European 'cancer curers' as an external application. In Southern Rhodesia, natives use the plant, among others, as a remedy for malaria, blackwater fever, Blood-poisoning, anthrax and dysentery, and as a 'war medicine'. The Sutos administer the ground-up seeds with bread or mealiepap to children during weaning. Suto women smoke cannabis to stupefy themselves during childbirth..."

In making these observations, we do not, of course, intend to minimise the fact that the use of dagga is a great social evil in South Africa.'

[34] This brief recourse to history is reflective of the manifestly impermissible racist and moralistic justifications used for the criminalisation of cannabis a century ago and should caution that the State must provide clear and plausible evidence tailored to the contemporary context to justify an infringement or an important right, being the right of privacy viewed in terms of autonomous acts in one's home. The

private moral views of a section of a community surely do not qualify as a legitimate justification in terms of s 36 of the Constitution dealing with the right to privacy.

**The evidence of the State**

[35] Much of the justification offered by the State turned on an affidavit deposed to by Dr Gouws, a pharmacist and a registrar of medicines who has served in various positions related to the control and regulation of medicine. In her affidavit, she states that:

> 'Cannabis contains over 400 compounds, including over 60 cannabinoids. The most potent of which is delta-9-tetrahydrocannabinol (THC), a psychoactive constituent. The cannabinoids have addictive synergistic or antagonistic effects with THC and may modify its actions. The non-cannabinoid constituents are associated with similar harms as tobacco when smoked. The content of THC is altered by the geographical area in which it is grown, although hydroponics are also used to increase the THC levels.'

[36] Dr Gouws contends that there are acute effects caused by cannabis, which include neurological effects on driving due to the lowering of cognitive skills, effects on the respiratory system and cardiovascular effects. In summary, Dr Gouws testified that the use of cannabis has harmful effects especially on the brain and body. It is a hallucinogen and causes a state of extreme relaxation or hyper activeness, depending on the user. Its harmful effects are also evident in, inter alia, pregnancy and learning.

[37] Dr Gouws also asserted that cannabis use in pregnancy may harm the foetus and further that chronic heavy cannabis smoking was associated with

increased symptoms of chronic bronchitis and that long terms cannabis smoking may increase the risk of respiratory cancer. Although she claims no direct knowledge of these risks, nor that she was an expert qualified to express an opinion on these alleged adverse effects of cannabis smoking, she states: 'a major factor to be considered is that cannabis is often used with other harmful drugs; consequently it is often difficult to ascertain whether cannabis is the solitary cause is the disease that afflicts uses'.

[38] In her affidavit she also referred to certain studies which she alleges have found that cannabis abuse increases the risk of developing of schizophrenia. Significantly no further medical evidence by an appropriately qualified medical expert such as a psychiatrist was placed before the Court. As the amici pointed out, by contrast in Prince 2 the State filed an affidavit by a psychiatrist, Professor Zabow.

[39] Dr Gouws concludes:

'Prevention of cannabis abuse therefore remains a necessity and a public health priority. This will contribute to achieving broad health and social benefits through the concurrent implementation of evidence-based prevention and treatment strategies to effectively reduce use, abuse an addiction.'

[40] The State also filed an affidavit by Captain Johan Smit, who deposed thereto on behalf of the South African Police Service, outlining his experience in the South African Narcotic Bureau and Organised Crime Unit in which he had served for more than 20 years. He noted that gangs and drug dealers deal in a variety of drugs, not only in cannabis. Accordingly, police records show that many drug uses commit crimes such as robbery, including armed robbery, housebreaking, robbery of business premises, assault and even murder in order to fund their drug addiction.

Further, many cases of domestic violence are related to drug use. In his view, the legalisation of drug use such as cannabis would not lead to a reduction of violent crimes as suggested by Professor Shaw et al.

[41] As I noted earlier in this judgment, following the report by Professor Shaw et al, the State filed further affidavits, one by Mr William Hofmeyr, Deputy Director of National Prosecutions, another supplementary affidavit by Captain Smit and a further affidavit by Dr Lochandra Naidoo. As Mr Hofmeyr's affidavit deals extensively with the approach by the fifth respondent to the prosecution of persons who contravene the Drugs Act and, in particular, to the approach of fifth respondent to diversion, I shall deal with this affidavit presently in this judgment.

[42] However, in response to the detailed report by Professor Shaw, et al it was surprising that the only further affidavit that was provided by the State dealing with health questions was deposed to by Dr Naidoo, who is a general medical practitioner. Accordingly, his qualifications as an expert in this field are hardly beyond contest, particularly in respect of psychiatric issues. Nonetheless, his affidavit remained the main response to the report by Professor Shaw et al and therefore it is important to examine his claims in assessing the overall justification for the limitation.

[43] Dr Naidoo points out that cannabis is the most widely used drug globally, that transition to cannabis or cocaine dependence occurs considerably more quickly than the transition to nicotine or alcohol dependence. Regular cannabis users are more likely to use other drugs such as heroin and cocaine and the younger the users when they first use cannabis, the more likely they are to transfer to other

drugs. He states, however, without any reference to any research study to justify the point:

> 'The most disturbing impact of cannabis use is to be found in the effects on the human brain, inter alia, memory loss and the abnormal processing of difficult tasks.'

In similar fashion, Dr Naidoo argues that the 'important effects on concentration and judgment functions on the brain prejudices education performances and outcomes'.

[44] Dr Naidoo then proceeded to question the motives of those arguing for decriminalisation. The following passage is illustrative:

> 'The lobby that is promoting an open society of drug use where decriminalised cannabis use is only the beginning to testing legislation and constitutions, is focused on ultimately legalising all controlled drugs. Unfortunately the lobby is also a major sponsor of research and researchers whose livelihood is derived from grants. Therefore more transparency of research funding and protocol is needed. Unfortunately, most of the dissemination is done through the lay press and will not bear the scrutiny of independent unbiased scientific panels'

[45] Further, in dealing with his differences to those of the United Nations Office of Drugs and Crime and its recommendations for the decriminalisation of cannabis, Dr Naidoo states as follows:

> 'No independent practitioner or association working in drug and alcohol treatment has recommended cannabis legalisation as they are regularly seeing the impact of cannabis use on the behaviour and health of their patients.'

[46] This unsubstantiated paragraph contrasts not only with medical and criminological evidence cited in the Shaw report but with additional expert evidence to which I shall refer presently.

[47] The report, by Professor Shaw et al as I indicated earlier, raised a series of important questions relating to justification of the limitation, as a result of which this Court provided respondents with an opportunity to answer, and of which Dr Naidoo's is the critical response thereto, save for the analysis of prosecuting policy raised by Captain Smit and Mr Hofmeyr respectively.

**The Shaw report**

Professor Shaw et al's report note that countries with more punitive anti-drug policies do not tend to have lower drug use prevalence levels than those with more liberal policies and the evidence is mixed at best that there was significant changes in drug use prevalence when countries shift their policies between more or less punitive approaches. In their submission, Professor Shaw et al refer to the work of Werb et al: State of the Evidence: Cannabis Use and Regulation (2015). The following table gleaned from Webb's book is reflective of this latter research:

COMMON CLAIMS ON CANNABIS USE

| CLAIM | STRENGTH OF SUPPORTING EVIDENCE | BOTTOM LINE |
|---|---|---|
| "Cannabis (is) as addictive as heroin." | Weak | A lifetime of cannabis use carries a low risk of dependence (9%), while the risk of cannabis dependence is very low among those who report using it for one year (2%) or even 10 years (5.9%). This is much lower than the estimated lifetime risk of dependence to heroin (23.1%). |
| "[D]id you know that marijuana is on average 300 to 400 percent stronger than it was thirty years ago?" | Moderate | Although this claim overstates the existing evidence, studies do suggest that there have been increases in THC potency over time in some jurisdictions. |
| "I'm opposed to legalising marijuana because it acts as a gateway drug" | Weak | Evidence to date does not support the claim that cannabis use causes subsequent use of "harder" drugs. |
| Cannabis use "can cause potentially lethal damage to the heart and arteries" | Weak | There is little evidence to suggest that cannabis use can cause lethal damage to the heart, nor is there clear evidence of an association between cannabis use and cancer. |
| Cannabis use lowers IQ by up to 8 points | Weak | There is little scientific evidence suggesting that cannabis use is associated with declines in IQ. |
| Cannabis use impairs cognitive function. | Moderate | While the evidence suggests that cannabis use (particularly among youth) likely impacts cognitive function, the evidence to date remains inconsistent regarding the severity persistence, and reversibility of these cognitive effects. |
| "(Cannabis) is a drug that can result (in) serious, long term consequences, like schizophrenia" | Weak | While scientific evidence supports an association between cannabis use and schizophrenia, a causal relationship has not been established. |

[48] Professor Shaw et al also note that harm reduction advocates tend to eschew criminal justice tools and to stress the primacy of the values of human rights and human dignity in all drug policy interventions. They also stress the need for interventions that are evidenced based, targeted and realistic. See for a further analysis Gerry Stimson 2007 International Journal of Drug Policy 67 which contains a detailed description of harm reduction strategies.

[49] Professor Shaw et al write thus:

> 'These principles – or even just the explicit identification of harm as the ultimate unit of analysis and concern – can and should cut across all drug policy alternatives. For example, just as they already inform many public health interventions with drug users, they can help inform the management of the cultivation or manufacture and trade in drugs. The entire question of managing "drugs" is one of balancing a wide and complex range of harms (and indeed benefits). This is a policy process which requires comprehensive intervention at the political level.'

[50] Significantly, Professor Shaw et al emphasise that 'many of those who motivate for an end to prohibition of (cannabis or drugs or prohibited activities) instead do so out of a keen appreciation of the harms at play – and out of a belief that the most successful management of those harms requires that the task be brought into the sphere of legal, transparent and constitutionally guided public institutions'.

[51] although Professor Shaw et al concede that they themselves are not medical experts, in contrasts to the assertions of Dr Gouws regarding psychopharmacological effect of cannabis, they examine significant literature in the field and conclude:

'The psychopharmacological effects of cannabis are no longer popularly understood to result in dangerousness and uncontrollable "reefer madness" and in fact many users are of the opinion that cannabis is more likely to induce passivity than help encourage any possible criminal behaviour. Perhaps surprisingly, the research on this is inconclusive. It may well be that cannabis, like alcohol, plays a disinhibiting role in certain possible crime situations (and others, for example involving risky sexual behaviour) especially for adolescents. However it is our view that the psychopharmacological effects of cannabis unlike those of some other drugs are unlikely to be a major contributor to levels of crime in South Africa.'

[52] Furthermore, on the basis of research cited in their report, while there may be tentative evidence of burglary and shoplifting committed specifically for money to buy cannabis, Professor Shaw et al suggest that this effect is likely to be limited, because, unlike other drugs, cannabis consumption is not understood to typically produce compulsive patterns of criminal behaviour. Furthermore, based on their own research, Professor Shaw et al state:

'[b]ased on our interviews conducted in going research around several illicit markets as well as the bulk of the evidence from abroad, it is our view that little of the systemic violence around the drug market in South Africa can be ascribed to cannabis. Unlike some other drugs it is not likely to contribute significantly to overall levels of violence.'

[53] The respondents have also not been able to establish that the prevention of violent criminal conduct serves as a legitimate purpose for the prohibition. Detective Smit states:

'The SAPS does not test suspects of the violent crimes for dagga, consequently, it is difficult to have stats with regard to dagga and crime. However, due to the fact

that dagga is a mind-altering drug, it, inter alia, impairs accountability. It would therefore not be far-fetched to surmise that it could play a role in the commission of crime.'

[54] This evidence is equivocal and speculative. Mr Pakade who is not qualified as an expert on this issue, also asserts that cannabis users display anti-social and violent behaviour. His evidence is also unsubstantiated.

[55] Relying on comparative evidence, where there has been decriminalisation, Professor Shaw et al contend that the justification for eschewing the use of the criminal law finds clear support. They note that there is no evidence that the decriminalisation of cannabis in certain USA States has resulted in spikes in crime. For example, in Colorado two years after decriminalisation and one year after the beginning of retail sales the evidence suggests that there had been no spikes in young people's use nor in road fatalities or crime; 'if anything there might have been slight decreases in both violent and property crime'.

[56] Turning to the range of international conventions which regulate drug usage, Professor Shaw et al note that a growing number of countries have begun to adopt policies that require creative interpretations of, or that arguably, are entirely impermissible under these various international conventions, namely the 1961 Single Convention on Narcotic Drugs amended in 1972, the 1971 Convention on Psychotropic Substances and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The development of alternative regulatory positions have been in practice for some time, including complete *de jure* decriminalisation (Uruguay) *de jure* decriminalisation through police discretion (Spain) *de jure* decriminalisation through administrative or civil discretion in

(Portugal and Czech Republic) *de jure* decriminalisation by way of judicial discretion (Germany and Peru) complete de facto decriminalisation (Netherlands) and *de facto* decriminalisation through judicial discretion (some US States).

[57] Portugal, for example, has since 2001 implemented a strategy whereby those found in possession of small quantities of drugs have these drugs confiscated and are given a ticket requiring them to appear before a "dissuasion board" consisting of two psychiatrists and a legal specialist to discuss their drug use. Here they risk a fine or a mandatory drug treatment with the majority of cases suspended with no sanction.

[58] Referring to the criminal regulation of cannabis in South Africa, Professor Shaw et al note that in 2014/15 SAPS made 251944 arrests which accounted for 15% of the total arrests in the country and which were pursuant to drug related crime. Drug related crime was responsible for more recorded charges than any other crime type beside a very broad category of "all theft not mentioned elsewhere". On the basis of figures gleaned from SAPS reports and, given that cannabis is the most commonly used illicit substance in South Africa, Professor Shaw et al submit that SAPS could free up significant resources if cannabis related enforcement was not made a priority, was decriminalised or legalised. Examining the SAPS figures further, Professor Shaw et al submit that it would appear that the bulk of the annual arrests for drug related crime represent the arrest of drug users or low levels suppliers 'caught in the act' rather than the result of any focused investigation. While conceding that cannabis offences in South Africa do not result in mass incarceration and therefore are not "filling prisons", Professor Shaw et al suggest that the evidence implies that these arrests fill holding cells and, to a lesser extent,

the roll of the courts and hence absorb a great deal of police resources and time. Accordingly, they argue that this does not represent an effective use of police and general criminal justice resources in a country with notoriously high levels of crime. In the view of Professor Shaw et al, a policy which seeks to pursue these cannabis users could result in major savings and allow for the direction of limited police resources into many other areas of crime which remain "unpoliced".

[59] In their report, Professor Shaw et al make reference to the approach of the South African Central Drug Authority which issued a position statement in the 2016 South African medical journal 569. The recommendations made by the authority are illuminating. They read thus:

> 'The national drug master plan emphasises the importance of an integrated approach to supply reduction, demand reduction and harm reduction strategies for combatting alcohol, tobacco, cannabis and other psychoactive substance use and abuse in SA. For any particular substance the balance between these three strategies and the precise nature of the approach should be evidenced based.
>
> An assessment of currently available data in other countries indicates that alcohol is the substance that causes the most individual and societal harm and is therefore key to put particular efforts into implementing the most evidenced based policies and interventions for combatting such harm. This would encompass addressing a range of upstream drivers of alcohol use as well as prevention and intervention efforts.
>
> Efforts at harm reduction have been particularly poorly resourced in South Africa and given the enormous profits made by the liquor industry there is a need and obligation for this industry to be substantially more involved in evidence based harm reduction efforts.

> In terms of cannabis, local schools survey data suggests high rates of experimentation during early adolescence; hence evidenced based interventions that include a strong focus on harm reduction are also needed in this population which comprises a large proportion of South Africans.
>
> There are few data to indicate that supply reduction via criminalisation is effective in reducing cannabis abuse. At the same time there are insufficient data to indicate that the legalisation of cannabis would not be harmful. The immediate focus should therefore be decriminalisation rather than legalisation.
>
> With regard to medical marijuana products based on the ingredients of the cannabis plants should undergo standard evaluation by the Medicines Control Council to assess their benefits and risks with treatment of particular medical conditions.'

[60] Contrary to the averments of Dr Gouws as well as that of Dr Naidoo, this statement by the Central Drug Authority of South Africa authored by Professor Dan Stein, the Head of the Department of Psychiatry and Mental Health, Faculty of Health Sciences UCT is of the view that decriminalisation is required to ensure that more productive strategies may be adopted to deal with this drug problem.

[61] This conclusion follows upon a 2016 report from the Royal Society for Public Health entitled "Taking a New Line on Drugs". In this report, the Royal Society recommends that lead responsibility for the UK Legal Drugs Strategy should be transferred to the Department of Health and more closely aligned with alcohol and tobacco strategies. Prevention of drug harm should also be conducted through universal, personal, social health and economic education. Evidence based drugs education should be a mandatory requirement in UK schools. It further recommended that decriminalising of personal use and possession of all illegal

drugs and diverting those whose use is problematic into appropriate support and treatment services instead is preferable, recognising that criminalising users most often only opens up the risk of further harm to health and wellbeing. Dealers, suppliers and importers of illegal substances would still be actively pursued and persecuted under the criminal law while evidence related to any potential benefits or harm from legal regulated supply should be kept under review.

[62] The eminent economist Dr Martin Wolf, writing in the *Financial Times* of 24 June 2016 in response to this report, said the following:

> 'The war on drugs is a fatuous idea. Force and fear cannot obliterate their use. Sensibly, society seeks to manage social costs of alcohol and tobacco while regulating their supply. This approach is not only applicable to other drugs but is also the only one that makes sense. Criminalisation is a dreadful mistake. This is not because drugs are harmless but rather because they are harmful. Containing harm and promoting health are indeed they only sane approach.'

[63] Much of the evidence that I have cited was published subsequent to evidence which was provided to the Constitutional Court in Prince 2. Nonetheless the Court's summation of the medical evidence presented to it in Prince 2 is instructive:

> '[25] Medical evidence on record indicates that cannabis is a hallucinogen. Although the medical experts who deposed to affidavits on the harmful effects of cannabis differed in their emphasis, on their evidence it is common cause that: the abuse of cannabis is considered harmful because of its psychoactive component, tetrahydrocannabinol (THC); the effects of cannabis are cumulative and dose-related: prolonged heavy use or less frequent use of a more potent preparation is associated with different problems; acute effects are experienced most quickly

when it is smoked; present clinical experience suggests that cannabis does not produce physical dependence or abstinence syndrome; and the excessive use of cannabis will result in a hypermanic or other psychotic state. However, "one joint of dagga, or even a few joints" will not cause harm.

[26] The harmful effect of cannabis which the prohibition seeks to prevent is the psychological dependence that it has the potential to produce. On the medical evidence on record, there is no indication of the amount of cannabis that must be consumed in order to produce such harm. Nor is there any evidence to indicate whether bathing in it or burning it as an incense poses the risk of harm that the prohibition seeks to prevent. The medical evidence focused on the smoking of cannabis and its harmful effects.

...

[61] On the medical evidence on record there can be no question that uncontrolled consumption of cannabis, especially when it is consumed in large doses poses a risk of harm to the user. An exemption that will allow such consumption of cannabis would undermine the purpose of the prohibition. However, on the medical evidence on record it is equally clear that there is a level of consumption that is safe in that it is unlikely to pose any risk of harm. The medical evidence on record is silent on what that level of consumption is. Nor is there any evidence suggesting that it would be impossible to regulate the consumption of cannabis by restricting its consumption to that safe level. All that the medical evidence on this record tells us is that the effects of cannabis are dose-related and cumulative and that while 'prolonged heavy use or less frequent use of a more potent preparation are associated with many different problems", "one joint of dagga or even a few joints" will not cause any harm.'

**Comparative law: the view from other democratic societies based on freedom, equality and dignity**

[64] In further justification of the limitation which confronts this Court, respondents relied on the Canadian Supreme Court decision in *R v Malmo-Levine* [2003] SCC 74. Two police officers arrested the appellant when they came alongside his van and smelt a strong odour of recently smoked marihuana. The appellant produced a partially smoked joint to the police officer which weighed 0.5 gram. It was clear that he possessed the joint for his own use and not for any other purpose. Marihuana under the relevant law was a scheduled drug and the penalty on summary conviction for possession of marihuana was a maximum fine of $1000 or imprisonment of up to six months or both for a first offence, and a maximum fine of $2000 or imprisonment for up to one year or both for a subsequent offence.

[65] The key dispute turned on whether the appellant's application for a declaration that the provision of the Narcotics Control Act prohibiting the possession of marihuana was unconstitutional and should have been denied at the trial. On the medical evidence, the majority of the court said:

> 'We have been shown no reason to interfere with these findings of fact. It seems clear that the use of marihuana has less serious and permanent effects than was once claimed, but its psychoactive and health effects can be harmful, and in the case of members of vulnerable groups the harm may be serious and substantial.' (613-614)

Turning to the justification for the relevant law, the majority of the Court per Gonthier and Binnie JJ said:

> 'The use of marihuana is therefore a proper subject matter for the exercise of criminal law power. Butler held .. that if there is a reasoned apprehension of harm Parliament is entitled to act, and in our view Parliament is also entitled to act on a

reasonable apprehension of harm even if on some points "the jury is still out". In light of the concurrent findings of 'harm' in the courts below we therefore confirm that the NCA in general and the scheduling of marijuana in particular properly falls within Parliament's legislative competence...' (at 621)

[66] The Court then examined the constitutional challenge under s 7 of the Canadian Charter of Rights and Freedoms which provides: 'Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.'

[67] The Court was confronted with the argument that the smoking of marihuana was integral to the appellant's preferred lifestyle and that the criminalisation thereof both in respect of possession and trafficking aspects was an unacceptable infringement of his personal liberty. In this connection, the majority of the court said the following with regard to the appellants invocation of s 7:

"While we accept Malmo-Levine's statement that smoking marihuana is central to his lifestyle, the Constitution cannot be stretched to afford protection to whatever activity an individual chooses to define as central to his or her lifestyle. One individual chooses to smoke marihuana; another has an obsessive interest in golf; a third is addicted to gambling.

...

In our view, with respect, Malmo-Levine's desire to build a lifestyle around the recreational use of marihuana does not attract Charter protection. There is no free-standing constitutional right to smoke "pot" for recreational purposes.' (623-624)

[68] The balance of the judgment concerned the imposition of possible imprisonment which, as the Court said, certainly "engages the appellant's liberty interest". Accordingly, it was necessary for the Court to examine the justification for whether imprisonment was appropriate in the circumstances. In this connection the majority of the Court, per Gonthier and Binnie JJ, said:

> 'The criminalisation of possession is a statement of society's collective disapproval of the use of a psychoactive drug such as marihuana (*Morgentaler, supra*, at p. 70), and, through Parliament, the continuing view that its use should be deterred. The prohibition is not arbitrary but is rationally connected to a reasonable apprehension of harm. In particular, criminalisation seeks to take marihuana out of the hands of users and potential users, so as to prevent the associated harm and to eliminate the market for traffickers. In light of these findings of fact it cannot be said that the prohibition on marihuana possession is arbitrary or irrational, although the wisdom of the prohibition and its related penalties is always open to reconsideration by Parliament itself.' (642-643)

[69] There was a compelling minority judgment of Arbour J which adopted the contrary position. She engaged in a sustained examination of the harm principle. Briefly, the harm principle is generally linked to the work of John Stuart Mill who established the principle that a constraint of liberties by the government is permitted in the following context: 'A person ought to be free to do as they want unless in doing so they violate a distinct and assignable obligation to someone else.' Mill also wrote:

> '[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.'

[70] In more recent times the philosopher Joel Feinberg (The Moral Limits of the Criminal Law(4 Volumes)) has, in addition, developed the related offense principle. He distinguishes between offensive actions and actions which are to be subjected to the offence principle. If a person is forced to suffer an offence regardless of whether or not actual harm results, that person is no less harmed and therefore government acts in legitimate fashion in regulating these offensive actions.

[71] Whatever view is adopted, as Arbour J said:

> 'Be it as a criminal sanction or as a sanction to any other prohibition, imprisonment must, as a constitutional minimum standard, be reserved for those whose conduct causes a reasoned risk of harm to others. "Doing nothing wrong" in that sense means acting in a manner which causes little or no reasoned risk of harm to others or to society. The Charter requires that the highest form of restriction of liberty be reserved for those who, at a minimum, infringe on the rights or freedoms of other individuals or otherwise harm society. (at 702-703)

[72] In evaluating the relevant evidence, Arbour J came to the following conclusion:

> 'In the cases before us, the societal interest in prohibiting marihuana possession must take into account, on the one hand, the burden that marihuana use imposes on the health care and welfare systems, and, on the other, the costs incurred by society because of the prohibition. Howard Prov. Ct. J. noted that at current rate of use, the costs imposed upon the health care and welfare systems by marihuana are negligible compared to the costs associated with alcohol and drugs. As I mentioned earlier, society's tolerance for the harmful effects that the conduct may entail must be assessed, where possible, by reference to its tolerance for comparable conduct. I will thus simply take note of the trial judges' findings that the burden that marihuana use imposes on society is "negligible" or "very, very small" compared to

> the costs imposed by comparable conduct that society tolerates (i.e., alcohol and tobacco use).
>
> If there remained any doubt as to whether the harms associated with marihuana use justified the state in using imprisonment as a sanction against its possession, this doubt disappears when the harms caused by the prohibition are put in the balance. The record shows and the trial judges found that the prohibition of simple possession of marihuana attempts to prevent a low quantum of harm to society at a very high cost. A "negligible" burden on the health care and welfare systems, coupled with the many significant negative effects of the prohibition, cannot be said to amount to more than little or no reasoned risk of harm to society. I thus conclude that s 3(1) and (3) of the Narcotic Control Act, as it prohibits the possession of marihuana for personal use under threat of imprisonment, violates the right of the appellants to liberty in a manner that is not in accordance with the harm principle, a principle of fundamental justice, contrary to s 7 of the *Charter*.'

[73] It is important to emphasise that s 7 of the Canadian Charter is not the equivalent of s 14 of the Constitution, in that the latter provides for a clearly demarcated right to privacy. Therefore, to that extent, the approach adopted by Arbour J and in particular, her application of the harm principle in relation to so core a right as privacy located in the context of autonomous individual behaviour within the sanctity of a person's home, is clearly more applicable, in my view, to the present dispute than the majority approach adopted in *Malmo-Levine*, *supra*.

[74] In dealing with comparative law there are three further cases which deserve attention, namely the *Arriola* ruling of the Supreme Court of Argentinia in respect of the possession of drugs for personal consumption, a decision of the Supreme Court of Alaska and more recently a decision of the Mexican Supreme Court.

**The *Arriola* case**

[75] On 25 August 2009 the Argentinian Supreme of Justice unanimously declared the second paragraph of Article 14 of the Argentinian Drug Control Legislation (Law Number 23,737) which criminalised the possession of drugs for personal consumption of prison sentences ranging from one month to two years to be unconstitutional. The Court found that this Article invaded the sphere of personal liberty which was excluded from the authority of State organs. Further, it incriminated the possession of drugs for personal use under circumstances that did not bring any concrete danger or harm to the rights and welfare of others, a finding which echoed the position of Feinberg as described above. The decision was interpreted as being based on the idea that a law that penalises the possession of drug for personal consumption and which thus invades the private sphere of individuals breaches the right of privacy which is protected by the Argentinian Constitution as well as international human rights instruments which were incorporated into Argentinian law. In this regard the court noted:

> 'Drug possession for personal consumption in itself does not provide any reason to affirm that the accused have carried out anything more than a private act or that they have offended public morals or the right of others.'

Significantly the court also found that the United Nations Drug Control Conventions did not obligate Argentinia to penalise drug possession for personal consumption. (Intercambios Asociacion Civil: September 1, 2009)

**Alaska**

[76] Some years earlier, in *Ravin v State of Alaska* (27 May 1975) the Alaskan Supreme Court was required to deal with constitutionality of the Alaskan statute for prohibiting possession of marihuana. The court held:

> "Thus, we conclude that citizens of the State of Alaska have a basic right to privacy in their homes under Alaska's constitution. This right to privacy would encompass the possession and ingestion of substances such as marijuana in a purely personal, non-commercial context in the home unless the state can meet its substantial burden and show that proscription of possession of marijuana in the home is supportable by achievement of a legitimate state interest." (para 12)

[77] The Court then turned to consider the evidence as to whether the state had demonstrated sufficient justification for the prohibition of possession of marihuana in general in the interest of public welfare; and further, whether the State had met the greater burden of showing a close and substantial relationship between the public welfare and control of ingestion or possession of marihuana in the home for personal use. See para 11.

[78] The Court summarised the evidence presented as follows:

> 'The State relies upon a number of medical researchers who have raised questions as to the substance's effect on the body's immune system, on chromosomal structure, and on the functioning of the brain. On the other hand, in almost every instance of reports of potential danger arising from marijuana use, reports can be found reaching contradictory results. It appears that there is no firm evidence that marijuana, as presently used in this country, is generally a danger to the user or to others. But neither is there conclusive evidence to the effect that it is harmless. The one significant risk in use of marijuana which we do find established to a

reasonable degree of certainty is the effect of marijuana intoxication on driving.' (para 12)

[79] The one area where the court was concerned was whether the consumption of marijuana constituted a potential harm when the targeted category were drivers under the influence of marijuana. Nevertheless, the court found that; 'these interests are insufficient to justify intrusions into the rights of adults in the privacy of their homes.' (para 20)

[80] The court concluded thus:

'We conclude that no adequate justification for the state's intrusion into the citizen's right to privacy by its prohibition of possession of marijuana by an adult for personal consumption in the home has been shown. The privacy of the individual's home cannot be breached absent a persuasive showing of a close and substantial relationship of the intrusion to a legitimate governmental interest. Here, mere scientific doubts will not suffice. The state must demonstrate a need based on proof that the public health or welfare will in fact suffer if the controls are not applied.'

**Mexico**

[81] More recently this same issue has been considered by the Supreme Court of Mexico in 2015. The court was required to decide whether adults could make a decision without State interference as to what type of recreational activities in which they wished to engage. The court found that this right allowed for the realisation of any actions and activities necessary to materialise this choice, notwithstanding that the right in question can be limited to pursue objectives protected by the Mexican Constitution, such as health or public order. However, the court found that the

system of prohibition was not a necessary measure to protect health and public order since there were other alternatives to achieve these objectives that have less onerous consequences for the right to the free development of a person's personality. The impugned measure impedes the consumption of marijuana under any circumstances when it could be limited to certain conduct or established more specific factual situations to fulfil these objectives.

[82] Significantly, the test the court adopted was as follows:

> 'The fundamental right adopts a double character; before going through the proportionality test, its contents have a *prima facie* nature. Only after it has passed such test, the contents of the right are definitive. Hence, if the legislative measure does not pass the proportionality test, the definitive contents of the right will coincide with its *prima facie* contents. To the contrary, if the provision merest the proportionality standard, the contents of the right will be more limited than those apparent or *prima facie*.' (These references to the Mexican Supreme Court are derived from translations from the official website of the Supreme Court of Justice of Mexico.)

**Conclusion in respect of this comparative law**

[83] While there are clear divisions in the legal approach to be adopted to the consumption of cannabis for personal use (see the difference between the majority decision in the Canadian Supreme Court in *Malmo-Levine* and the further references to comparative law cited in this judgment), the reasoning adopted by a number of the courts which upheld challenges to the relevant laws and to which

reference has been made are important. As Khampepe J noted in *AB and another v Minister of Social Development* [2006] ZACC 43 at para 132:

> 'For the purposes of conducting a limitation analysis, the nature of the rights infringed also gives substance to the terms "human dignity", "equality" and "freedom". In establishing the meaning of these terms, s 36(1) requires that we determine what is reasonable and justifiable "in an open and democratic society" This leaves scope to examine the way in which foreign jurisdictions regulate surrogacy. What other open and democratic societies consider appropriate can be of assistance in determining what is reasonable and justifiable in our own.'

[84] Accordingly, the fact that there has been a significant change in approach by a number of Courts and legislation to what was previously a general prohibition against the consumption of cannabis, even for personal consumption, is significant.

[85] I am indebted in this particular connection to the meticulous research conducted by the amici with regard to the changing nature of the legal regimes viewed comparatively. In summary: In the United States of America eight states have legalised the possession of cannabis in small quantities for personal use, namely: Alaska, California; Colorado; Washington; Maine; Massachusetts; Nevada and Oregon. The federal prohibition on such conduct is no longer enforced in these states.

[86] In Canada, the possession, use and cultivation and transportation of cannabis is currently illegal and subject to sanction in terms of Controlled Drugs and Substances Act. However, the Canadian government has publicly announced that it intends to enact legislation this year that will legalise the possession of small

quantities for personal consumption. It has appointed a special task team to investigate the most appropriate approach.

[87] On 20 December 2013 with the enactment of Law 19.172 Uruguay legalised cannabis for recreational use. In terms of Law 19.172 the state controls the entire cannabis industry chain, from production to consumption.

[88] Jurisdictions that have decriminalised the possession of cannabis in small quantities for personal use include: certain territories in Australia (Australian Capital Territory; Northern Australia, Southern Australia) Austria; Chile; Czech Republic; Estonia, Jamaica ; Portugal, Spain; Switzerland and 13 states of the United States of America (Connecticut, Delaware; Illinois; Maryland; Minnesota; Mississippi; Missouri, New York; North Carolina; Ohio; Rhode Island and Vermont).

[89] On 28 August 2013, the US Attorney General announced that federal executive agencies would no longer enforce the federal prohibition in states that have legalised or decimalised the possession cannabis. The Drug Enforcement Administration will enforce federal law only if an offence triggers one of eight new federal enforcement priorities, such as an offence involving violence or firearms, where proceeds go to a gang or a cartel, where cannabis is distributed to a minor or in those states where cannabis remains illegal.

[90] As the amici note, these international developments reflect a clear shift in a consensus in what can be considered to be open and democratic societies, that the criminalisation and possession of cannabis for personal use is no longer effective in preventing harm. In short, there is no longer a consensus that can regard such limitations as justifiable.

**Evaluation**

[91] The starting point for the evaluation of whether a limitation on a right enshrined in Chapter 2 of the Constitution is justifiable is contained in the principle that it is the State that bears the burden of justification. Not only was respondents' medical evidence provided by Dr Gouws contested, but respondents offered very little further evidence of persuasion and weight to counter the report by Professor Shaw *et al*. Furthermore, the approach adopted by the Central Drug Authority of South Africa together with the comparative medical evidence set out above have to be taken into account in formulating a conclusion as to whether respondents have discharged the burden placed upon them.

[92] The evidence provided by respondents, in my view, was singularly unimpressive, particularly in that a considerable period of time was offered to respondents in order to respond comprehensively to the Shaw report. All that was forthcoming was a further affidavit by Captain Smit, an affidavit by a general practitioner, whose expertise is surely open to doubt in this specific area and who made a number of unsubstantiated claims. On its own this was a disappointing answer to the persuasive arguments made by Professor Shaw et al.

[93] Arguably the most significant evidence provided by respondents was the affidavit to which I have made reference earlier, namely that of Mr William Hofmeyr the Deputy National Director of Public Prosecutions. It is to that affidavit that I must now turn.

[94] The purpose of Mr Hofmeyr's affidavit as he states, was to deal with some of the conclusions reached by Professor Shaw et al, including the concept of diversion and the proposed alternative dispute resolution mechanism. Significantly Mr

Hofmeyr noted that the NPA has introduced various forms of alternative dispute resolution methods in this regard, including plea bargains, formal or informal diversion in the trial of adults and juveniles and informal mediation which affords the prosecutor the opportunity to mediate between the victim and an offender in order to resolve the dispute caused in a criminal case.

[95] Mr Hofmeyr then emphasised the importance of diversion stating:

> 'A major advantage of diversion is that, unlike the mere withdrawal of cases, it seeks to ensure that the offender takes responsibility for his actions and undergoes corrective measures which will be beneficial to him in the future.'

[96] In making this decision, the NPA is assisted by the Department of Social Welfare which is primarily responsible for the diversion program together with some nongovernmental organisations such as the South African National Institute for Crime Prevention and Reintegration of Offenders ("NICRO").

[97] Mr Hofmeyr then proceeds to deal with the application of the diversion program in the various provinces in South Africa. For example, in describing the position in Limpopo he states as follows:

> 'Cannabis is the main drug used in Limpopo and accounts for 38 910 of the 47 777 (81%) drug cases opened;
>
> In 2016/17 to 30 September, 5401 cases involving cannabis were reported and the counts dealt with then in the following manner:
>
> 1. 6352 were referred to the Court;
> 2. 949 were withdrawn;
> 3. 4198 of the cases were convictions;
> 4. 2695 followed the alternate dispute program or the diversion program.
> 5. 21 of the cases were acquittals.'

Turning to South Gauteng, Mr Hofmeyr states:

'A total received of 2893 cases were received.

50% of the cases were finalised by way of diversion where –

1. The weight of cannabis found was less than 10g;
2. The accused pleaded guilty; and
3. The accused met the requirements of being a first offender and he/she can be monitored.

95% of the cannabis cases placed on the roll resulted in convictions;

In matters where there are large volumes of cannabis, the matter will be prosecuted in the normal course.'

Mr Hofmeyr then dealt with the Western Cape where he said the following:

'Some of the responses received from the Western Cape DPP office highlighted the following in respect of court process and the withdrawal of court cases:

1. Cases are usually withdrawn or removed from the roll due to forensic reports not being available within a reasonable time;
2. Only in a limited number of cases is a prosecution declined because of some material deficiencies. This would happen where evidence or incompleteness of the investigation. However, a larger number of drugs cases are finalised through the court process;
3. There does not appear to be a major challenge with missing charge sheets , and this is not a major reason for the withdrawal of charges;

The Western Cape DPP offices will always consider diversion.

1. In respect of possession cases, more than 90% of cases that are prosecuted are for small amounts. Consequently, courts very seldom impose direct imprisonment or set a substantial fine.
2. In cases where the accused are youthful and/or first offenders and they admit guilt, cases are usually disposed of by way of an Alternate Dispute resolution.

The Western Cape DPP offices also utilise Priority Courts as a means of achieving expeditious justice for drug related matters. Priority Court cases are dealt with differently. Cases that meet the criteria set out below are referred to the Priority Court in Khayelitsha:

1. Where the value of the drugs is R50 000 or more;
2. Where the profile of the accused warrants prioritizing even if the value is less than R 50 000;
3. Arrests at well known drug outlets during raids, s 252 traps or searches even if the value is less than R 50 000.'

[98] From reports which Mr Hofmeyr received from the Pretoria area, he arrived at the following conclusions:

1. Admissions of guilt fines are fixed in matters where small quantities of dagga were found. This is done in accordance with the guidelines in the NPA Policy manual;
2. Few if any cases are dismissed due to lost charge sheets;
3. Cases are withdrawn for further investigations;
4. The majority of cases involved the possession of relatively small quantities of dagga.'

[99] Based on this information, Mr Hofmeyr concludes:

'It is inaccurate to say that the current law simply punishes offenders by way of incarceration. As set out above, drug users, and especially juvenile offenders, have the opportunity to participate in the various programs that are available. In the premises the NPA avers that there are sufficient alternative dispute resolution methods and policy measures that deal with offences related to drugs without the need for a policy change on the criminalisation of the use and possession of cannabis.'

**Implications of Mr Hofmeyr's affidavit**

[100] This conclusion of Mr Hofmeyr, contained in an affidavit deposed to by respondents in support of the justification for the limitation of the right of privacy, is of particular significance. It would appear from this affidavit that commendably, the NPA already recognises the problem of the blunt instrument of the criminal law being employed insofar as the possession and consumption of cannabis strictly for personal use is concerned. Diversion is a policy approach which appears to have gained significant traction within the NPA. In itself, this leads to the conclusion that the NPA itself recognises the limitations contained in the strictly wording of legislation which provides for the use of the criminal law as the default censure for possession for personal use and consumption of cannabis. However, the evidence provided by the NPA shows that in the absence of a national and uniform diversion policy with clear guidance as to its application, individual prosecutors may apply a different discretion in various jurisdictions. This could result in a level of arbitrary enforcement or inconsistency contrary to the guarantee in s 9(1) of the Constitution that is equality before the law.

[101] In summary, if the NPA considers that a policy of diversion may be the more appropriate approach to personal consumption use in the context of cannabis in South Africa, this adds weight to the broader argument that the criminalisation of the use of cannabis for personal use and consumption is open to significant doubt. Diversion and other policy choices as opposed to the blunt use of the criminal law and, in particular, imprisonment, support the conclusion that the state cannot justify the prohibition as contained in the impugned legislation as it stands at present. To recall, Mr Prince in his affidavit, stated:

'To argue that the restriction is unlawful because it protects adults and adolescence against harm is ambiguous vague and embarrassing. The law does not proscribe alcohol, tobacco, doughnut eating, horse-riding, bungee jumping, white water rafting, rugby and soccer because all of the aforementioned can be harmful to humans. We obviously only proscribe activity if the harm is non trivial or crosses a certain threshold whilst acknowledging that an adult individual living in a democracy has the right to engage in acts of self-endangerment.'

[102] Expressed in legal terms, the evidence as set out in this judgment supports the argument that the legislative response to personal consumption and use is disproportionate to the social problems caused as a result thereof. Both ss 4 and 5 of the Drugs Act need to be amended to ensure that these provisions do not apply to those who use small quantities of cannabis for personal consumption in the privacy of a home as the present position unjustifiably limits the right to privacy. It is the legislature that should determine the extent of what would constitute small quantities in private dwellings.

[103] Even if it can be shown that there a legitimacy to the objectives of the limitation and further that this legitimate objective is rationally connected to the means employed by way of the impugned legislation, this is not sufficient to prove a justification required in terms of s 36(1) of the Constitution.

[104] Notwithstanding the contested evidence, assume that respondents are correct that the objectives of prevention of abuse, a reduction in crime prevention of negative effects on driving ability, and detrimental neurological effects on driving ability, detrimental neurological effects and upon the cardiovascular and respiratory systems (see Dr Gouw's affidavit at paras 62 ff) are met by the impugned legislation.

Respondents would still need to show why a less restrictive means to achieve the purpose does not exist. In other words, even if the Court finds that the evidence of Prof Shaw et al, the further evidence cited in their report, including the views of the Central Drug Authority of South Africa, does not carry sufficient evidential weight, if respondent wishes to restrict so important a rights as a private act of consuming cannabis in the intimacy of a home it should attempt to employ means of doing so which are the least restrictive of the right(s) being infringed. The limitation should in other words be narrowly tailored to achieve its purpose, that it should be carefully focused or that it should not be overbroad.

[105] In his dissenting judgment in *Malmo-Levine, supra* at para 280, Lebel J captures this point:

> 'In my mind, it cannot be denied that marihuana can cause problems of varying nature and severity to some people or to groups of them. Nevertheless, the harm its consumption may cause seems rather mild on the evidence we have. In contrast, the harm and the problems connected with the form of criminalisation chosen by Parliament seem plain and important. ...
>
> [T]he enforcement of the law has tarred hundreds of thousands of Canadians with the stigma of a criminal record. They have had to bear the burden of the consequences of such criminal records .. the fundamental liberty interest has been infringed by the adoption and implementation of a legislative response which is disproportionate to the societal problems at issue.'

[106] The evidence, read as a whole, cannot be taken to justify the use of criminal law for the personal consumption of cannabis. The present prohibition contained in the impugned legislation does not employ the least restrictive means to deal with a social and health problem for which there are now a number of less restrictive

options supported by a significant body of expertise. The additional resources that may be unlocked for use of policing of serious crimes cannot be over emphasised.

**Overall conclusion**

[107] A finding that respondents have not discharged the burden of justifying the limitation of the right to privacy should not be construed as meaning that this court wishes, in any way, to understate the importance of curbing drug trafficking and the pernicious and socially destructive activities of drug dealers But this case is only concerned with acts / conduct of individuals performed in the confines of their own homes when they invoke a right to autonomy as expressed in the privacy of their own homes. This judgment must, thus, not be read to extend any further than the narrow confines of the dispute as I have defined it. It is necessary to emphasise that this Court is acutely aware of the challenges regarding drug abuse as well as the prevalence of drug usage amongst minors and school going children. It is also important to state that this case does not extend to children as defined. Children must be protected from any harm caused by exposure to drugs. The point of this judgment is that there are a multitude of options available to fight this problem as opposed to the blunt use of the criminal law. It is precisely for this reason that this Court contends that less restrictive means must be employed to deal with the problem; a conclusion clearly advocated in the position articulated by the Central Drug Authority cited earlier.

[108] While the applicants seek a range of remedies, including the legalisation of the use of cannabis, in my view to make such decisions would intrude upon the

legitimate competence of the legislature and the executive. The evidence, holistically read together with the arguments presented to this court, suggests that the blunt instrument of the criminal law as employed in the impugned legislation is disproportionate to the harms that the legislation seeks to curb insofar as the personal use and consumption of cannabis is concerned. This conclusion is supported by the importance of the core component of the right to privacy and, further, by the cautious approach that must be taken to the evaluation of the criminalisation of cannabis which, as indicated earlier in this judgment, is certainly characterised by the racist footprints of a disgraceful past.

[109] In this connection the 1998 Convention against Illicit Traffic and Narcotic Drugs and Psychotropic Substances establishes a fundamental distinction between 'the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption (article 32 (2)) from trafficking and dealing conduct (article 3(1), conduct which is described as 'serious'). This distinction is reflected in the differential regulation in the Drugs Act of possession for personal use (s 4) and dealing (s 5). The Drugs Act recognises, for example, that when it comes to possession for purposes of personal use, smaller quantities are involved. Hence, the Act created a presumption that a person found in possession of cannabis exceeding the prescribed mass was presumed to be dealing. Section 21 (1)(a)(i) of the Drugs Act presumes that a person possessing more than 115 grams of cannabis is dealing. The provision has, however as noted, been declared unconstitutional in *S v Bhulwana; S v Gwadiso* 1996 (1) SA 388 (CC). The quantity of cannabis in a person's possession constitutes an objective, established and readily enforceable basis upon which to distinguish possession for personal consumption from dealing or other, more serious conduct. Whether the existing

prescribed quantity should remain applicable in the light of the finding of this Court is for the legislature to determine, hence any reading in of words into the Drugs Act is not an appropriate approach in this case.

[110] It follows, unlike the position of the majority in Prince 2, who were dealing with a different regime, that I find that it would be practical and objectively possible for legislation to distinguish the use of cannabis and the possession, purchase or cultivation of cannabis for personal consumption from other uses.

[111] The further question concerns the powers of judicial review. South Africa is not a juristocracy; that is the judiciary does not run the country but rather shares constitutional competence with the legislature and executive. While courts must retain the power to determine the legality and constitutionality of any legal provision, a Court must limit its reach by ensuring that it is the political branches of the State which fashion policy and develop alternative responses to social and political mischief which require legislative intervention. As Woolman et al Constitutional Law South Africa para 34-8 state the analysis 'must be understood in terms of norm setting behaviour that provides guidance to other state actors without foreclosing the possibility of other effective safeguards for rights or other useful methods for their realisation.' This submission must also apply to the development of a justifiable limitation on rights enshrined in Chapter 2 of the Constitution.

[112] What this means for the present dispute is that it is not for this Court to prescribe alternatives to decriminalisation of the use of cannabis for personal use and consumption. It is for the legislature and the executive to decide on a suitable option or alternatives which can be made after these have been the subject of a

deliberative process which is inherent in the idea of Parliament. But as private conduct is prescribed by law, it is within the competence of a Court to hold that the impugned law fails to pass constitutional muster. To that extent, a Court plays a role in the overall response to the problems raised by the present dispute.

**International Law**

[113] Respondent contended that South Africa had undertaken to be bound by the provisions of a series of international conventions, including the Southern African Development Community Protocol on Combating Illicit Drugs 2006 (Southern African Drugs Protocol) and the United Nations Single Convention on Narcotic Drugs 1961, and to take the appropriate steps to participate in the global war against drugs. Once South Africa had signed such agreements, they had to be tabled before Parliament for approval. Upon parliamentary approval the legislation is binding on the Republic (s 231 of the Constitution).

[114] In this respondents referred to *Glenister v President of the RSA and others* 2011 (7) BCLR 651 (CC) at para 189 where the Constitutional Court made the following observations that, once approved, the legislation is not only binding on the Republic but has domestic constitutional effect:

> 'The obligations in these Conventions are clear and they are unequivocal. They impose on the Republic the duty in international law to create an anti-corruption unit that has the necessary independence. That duty exists not only in the international sphere, and is enforceable not only there. Our Constitution appropriates the obligation for itself, and draws it deeply into its heart, by requiring the state to fulfil it in the domestic sphere. In understanding how it does so, the starting point is s 7(2),

> which requires the state to respect, protect, promote and fulfil the rights in the Bill of Rights. This Court has held that in some circumstances this provision imposes a positive obligation on the state and its organs "to provide appropriate protection to everyone through laws and structures designed to afford such protection". Implicit in s 7(2) is the requirement that the steps the state takes to respect, protect, promote and fulfil constitutional rights must be reasonable and effective.'

[115] Under article 6(2) of the Southern African Drugs Protocol member states are required to institute appropriate and effective measures to promote co-operation between law enforcement agencies.

[116] According to respondents this agreement gives rise to an obligation on the part of South Africa to enact legislation which will achieve this purpose. The obligation is not limited to the international sphere. It is binding and enforceable with equal force in South Africa. The submission is correct, but there is nothing in the Drugs Protocol that specifically prohibits measures to deal with private consumption of drugs other than through criminalisation.

[117] For the sake of completeness South Africa is a signatory to the Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol ("the Single Convention); the Convention on Psychotropic Substances, 1971; and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 ("the 1998 Convention").

[118] The Convention on Psychotropic Substances, 1971 does not apply to cannabis. In the case of the two remaining conventions, they both contain exemptions which make the duty to adopt criminal sanctions subordinate to the

provisions of a state's constitution. In terms of article 36(1)(a) of the Single Convention, the criminalisation of the listed forms of conduct must take place subject to each party's "constitutional limitations".

[119] The 1988 Convention provides that, the duty of a state party to establish as a criminal offence under its domestic law the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption is made subject to a Party's 'constitutional principles and the basic concepts of its legal system'.

[120] Significantly Ngcobo J, found in Prince 2 that these international conventions are no bar to an exemption that may be required by our Constitution (para 72), a finding that does not appear to be inconsistent with the majority judgment.

[121] The 1998 Convention distinguishes conduct, which is regarded as "particularly serious". (article 3(1)) and can broadly be described as trafficking and dealing, from conduct, which is "the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption". (article 3(2)) The distinction governs both the duty to criminalise and to punish.

[122] The duty on each state party to 'adopt such measures as may be necessary to establish as criminal offences under its domestic law' in respect of the conduct contemplated in article 3(1) is unqualified by any constitutional consideration. The offences in article 3(1) must be 'liable to sanctions which take into account the grave nature of these offences, such as imprisonment or other forms of deprivation of liberty, pecuniary sanctions and confiscation'

[123] By contrast, the duty 'to establish as criminal offences under its domestic law' in respect of the conduct contemplated in article 3(2) is subject to a Party's 'constitutional principles and the basic concepts of its legal system'. Criminal conviction and punishment is not compulsory for article 3(2) conduct: 'The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender.

[124] In this connection, the International Narcotic Control Board, the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions, established in accordance with the Single Convention, has stated:

> 15. None of the [international] conventions require[s] illicit drug consumption per se to be established as a [criminal] offence. Instead the conventions deal with illicit drug consumption indirectly in their provisions on activities such as the cultivation, purchase or possession of illicit drugs. In so far as these activities are engaged in for the purpose of non-medical personal consumption:
>
> (a) Parties to the 1961 Convention and the 1971 Convention may take the view that they are not required to establish such activities as criminal offences under law. The basis for this view appears to be that, since obligations relating to penal provisions appear among articles relating to illicit traffic, the obligations only apply to cultivation, purchase or possession for the purpose of illicit trafficking;

(b) Unless to do so would be contrary to the constitutional principles and basic concepts of their legal systems, only the 1988 Convention clearly requires parties to establish as criminal offences under law the possession, purchase or cultivation of controlled drugs for the purpose of non-medical personal consumption;

(c) None of the conventions requires a party to convict or punish drug abusers who commit such offences even when they have been established as punishable offences. The party may choose to deal with drug abusers through alternative non-penal measures involving treatment, education, aftercare, rehabilitation or social reintegration.' (Emphasis added.)

[125] While the unqualified and wholesale legalisation of cannabis may contravene South Africa's international obligations, it does not follow that even the legalisation of the 'possession, purchase or cultivation of [cannabis] for personal consumption' where such legalisation is a consequence of South Africa's 'constitutional principles and the basic concepts of its legal system' amounts to a contravention of its international obligations; indeed to the contrary. How much more so does this conclusion hold for decriminalisation!

**Strike out application**

[126] Mr Bokaba who appeared with Ms Poswa-Lerotholi, Mr Jara and Mr Mhlana for respondents submitted that the applicants had been warned in respondents

answering affidavits that objection was taken to the inadmissible hearsay, argumentative matter and inadmissible opinion evidence contained in their papers, which included reliance on numerous newspaper articles and third party statements as well as statement from unidentified and unnamed sources.

[127] Specific objection was taken to the content of four volumes, produced by Mr Acton, the credibility of the research and expert evidence of which was questioned. In Mr Bokaba's view the articles contained in the four volumes upon which Mr Acton sought to rely were not created for purposes of litigation. In his view they were comprised of a melange of media reports, analyses, opinion, some attributed others not and conclusions based on facts which had not been introduced as evidence in these proceedings.

[128] Some of the contents of these volumes contain reports of various commissions of inquiry and published articles while it is correct that there are also a number of documents prepared by Mr Acton who is not a qualified expert.

[129] Given that Mr Acton is not a lawyer and represented himself, some level of generosity may be appropriate. Suffice to say that this Court made no use of any of these documents and hence did not decide to strike any out. In short, the disposition of this case did not require a determination of the strike out application.

**Order**

[130] This Court must invoke its powers under s 172 (1) (b) of the Constitution to order a suspension of the declaration of invalidity for a realistic period to ensure

Parliament may correct the defect. In my view, a period of 24 months from the date of this judgment would be appropriate. The order also makes clear that the relevant provisions are only unconstitutional to the extent that they trench upon the private use and consumption of a quantity of cannabis for personal purposes, which the legislative considers does not constitute undue harm.

[131] In the interim period, it is necessary to provide that prosecutions that fall within legal provision declared to be unconstitutional should be stayed.

[132] For these reasons the following order is made

1. The following provisions are declared inconsistent with the Constitution of the Republic of South Africa Act 108 of 1996 and invalid, only to the extent that they prohibit the use of cannabis by an adult in a private dwellings where the possession, purchase or cultivation of cannabis is for personal consumption by an adult:
   1.1. sections 4(b) and 5(b) of the Drugs and Drug Trafficking Act 140 of 1992 (the Drugs Act) read with Part III of Schedule 2 to the Drugs Act; and
   1.2. section 22A(9)(a)(i) of the Medicines and Related Substances Control Act 101 of 1965 (the Medicines Act) and s 22A (10) thereof read with schedule 7 of GN R509 of 2003 published in terms of s 22A(2) of the Medicines Act.

2. This declaration of invalidity is suspended for a period of 24 months from the date of this judgment in order to allow Parliament to correct the defects as set out in this judgment.

3. It is declared that until Parliament has made the amendments contemplated in paragraph 1 or the period of suspension has expired, it will be deemed to be a defence to a charge under a provision as set out in paragraph 1 of this order that the possession, or cultivation of cannabis in a private dwelling is for the personal consumption of the adult accused.

DAVIS J

I agree

SALDANHA J

I agree

BOQWANA J

## Appendix II: Data collection sheet

| **Study number** | | |
|---|---|---|
| **Sex** | **Male** | **Female** |
| **Age** | | |

| **Education** | **Yes** | **No** |
|---|---|---|
| In school | | |
| HLOE | | |

| **Substances** | **Yes/no** | **Age of debut** | **Past/current** | **Frequency Daily/weekly/monthly** | **Urine toxicology** |
|---|---|---|---|---|---|
| Cannabis | | | | | |
| Methamphetamines | | | | | |
| Alcohol | | | | | |
| Other - Nicotine/Opiates | | | | | |

| **Psychiatric presentation** | **Yes** | **No** |
|---|---|---|
| Index | | |
| Previous admissions | | |
| If yes, total number? | | |

| **Psychiatric Diagnosis on discharge/transfer** | |
|---|---|

| **Stressors/Social issues** | **Yes** | **No** |
|---|---|---|
| Previous experience of trauma Physical/ Neglect/ Sexual/ Verbal | | |
| Family conflict | | |
| Bereavement | | |
| Bullying | | |
| Other – specify | | |
| **Family history** | **Yes** | **No** |
| Substances<br>If yes, specify mother/family member | | |
| History of psychiatric disorder<br>If yes, specify | | |

| **Co-morbid Medical Conditions** | Yes | No |
|---|---|---|
| Epilepsy | | |
| Head Injury | | |
| HIV Status | | |
| Chronic illness - specify | | |

## Appendix III: UCT Human Research Ethics Committee Approval

**UNIVERSITY OF CAPE TOWN**
**Faculty of Health Sciences**
**Human Research Ethics Committee**

**Room G50- Old Main Building**
**Groote Schuur Hospital**
**Observatory 7925**
**Telephone** [021] 406 6492
**Email:** hrec-submissions@uct.ac.za
**Website**: www.health.uct.ac.za/fhs/research/humanethics/forms

26 July 2021

**HREC REF: 398/2021**

**Dr L Dannatt**
Division of Psychiatry & Mental Health
Neuroscience Building-GSH
Email: Lisa.danatt@uct.ac.za
Student: micswa2@gmail.com

Dear Dr Dannatt

**PROJECT TITLE: A REVIEW OF CANNABIS USE AMONG ADOLESCENTS PRESENTING TO A TERTIARY PSYCHIATRIC UNIT IN CAPE TOWN, SOUTH AFRICA, BEFORE AND AFTER THE HIGH COURT RULING IN 2017 TO DECRIMINALIZE CANNABIS. (MMED DEGREE - DR MICHELLE SWARTZ)**

Thank you for your letter to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**This approval is subject to strict adherence to the HREC recommendations regarding research involving human participants during COVID -19, dated 17 March 2020 & 06 July 2020.**

**Approval is granted for one year until the 30 July 2022.**

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

***The HREC acknowledge that the student: Miss Michelle Swartz will also be involved in this study.***

**Please quote the HREC REF 398/2021 in all your correspondence**.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

Signed by candidate

**PROFESSOR M BLOCKMAN**
**CHAIRPERSON, FACULTY OF HEALTH SCIENCES HUMAN RESEARCH ETHICS COMMITTEE**
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
NHREC-registration number: REC-210208-007

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use: Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2020), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines. The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

# FHS017: Annual Progress Report / Renewal

## Record Reviews/Audits/Collection of Biological Specimens/Repositories/Databases/Registries

| | | | |
|---|---|---|---|
| **HREC office use only (FWA00001637; IRB00001938)** | | | |
| **This serves as notification of annual approval, including any documentation described below.** | | | |
| ☑ Approved | Annual progress report | Approved until/next renewal date | 30-7-23 |
| ☐ Not approved | See attached comments | | |
| Signature Chairperson of the HREC/ Designee | Signed by candidate | Date Signed | 19/7/22 |

**Note:** Please note that incomplete submissions will not be reviewed.
Please email this form and supporting documents (if applicable) in a combined pdf-file to hrec-enquiries@uct.ac.za.

Please clarify your plan for research-related activities during COVID-19 lockdown

HUMAN RESEARCH ETHICS COMMITTEE
19 JUL 2022
HEALTH SCIENCES FACULTY
UNIVERSITY OF CAPE TOWN

## Principal Investigator to complete the following:

### 1. Protocol information

| | | | |
|---|---|---|---|
| Date (when submitting this form) | 12/07/2022 | | |
| HREC REF Number | 398/2021 | Current Ethics Approval was granted until | 30/07/2022 |
| Protocol title | A review of cannabis use among adolescents presenting to a tertiary psychiatric unit in Cape Town, South Africa, before and after the high court ruling in 2017 to decriminalize cannabis | | |
| Principal Investigator | Dr Lisa Dannatt | | |
| Department / Office Internal Mail Address | lisa.dannatt@uct.ac.za | | |
| 1.1 Does this protocol receive US Federal funding? | | ☐ Yes | ☑ No |

### 2. Protocol status (tick ✓)

| | |
|---|---|
| ☐ | Research-related activities are ongoing |
| ☑ | Data collection is complete, data analysis only |
| Please indicate (in the block below) the titles and HREC reference numbers of any projects currently making use of the Database/registry/repository. | |
| | |

### 3. Protocol summary

| | | |
|---|---|---|
| Total number of records or specimens collected, reviewed or stored since the original approval | | 266 |
| Total number of records or specimens collected, reviewed or stored since last progress report | | |
| Have any research-related outputs (e.g. publications, abstracts, conference presentations) resulted from this research? If yes, please list and attach with this report. | ☐ Yes | ☑ No |

### 4. Signature

| | | | |
|---|---|---|---|
| Signature of PI | Signed by candidate | Date | 19/7/2022 |

# Appendix IV: Groote Schuur Hospital Research Ethics Committee Approval

Western Cape Government
Health

**GROOTE SCHUUR HOSPITAL**
**Enquiries**: Dr Bernadette Eick
**e-mail**: GSHReserach.Request@westerncape.gov.za

Dr Lisa Dannatt
**PSCYCHIATRY & MENTAL HEALTH**

E-mail: Lisa.Dannatt@uct.ac.za / micswa2@gmail.com

Dear Dr Dannatt,

**RESEARCH PROJECT: A Review Of Cannabis Use Among Adolescents Presenting To A Tertiary Psychiatric Unit In Cape Town, South Africa, Before And After The High Court Ruling In 2017 To Decriminalise Cannabis (MMed. Dr Michelle Swartz)**

Your recent letter to the hospital refers.

You are granted permission to proceed with your research, which is valid until **30 May 2022.**

Please note the following:

a) Your research may not interfere with normal patient care.
b) Hospital staff may not be asked to assist with the research.
**c) Confidentiality must always be maintained.**
**d)** No additional costs to the hospital should be incurred as indicated in your Annexure 2 i.e. Lab, consumables or stationery. **If access to TRACK Care/NHLS is required, kindly attach our letter of approval to the application form and approach Information Management to assist with data.**
e) **No patient folders may be removed from the premises or be inaccessible.**
f) Please provide the research assistant/field worker with a copy of this letter as verification of approval.
**g) Should you at any time require photographs of your subjects, please obtain the necessary indemnity forms from our Public Relations Office (E45 OMB or ext. 2187/2188).**
h) Should you require additional research time beyond the stipulated expiry date, please apply for an extension.
i) Please discuss the study with the HOD before commencing.
j) Please introduce yourself to the person in charge of an area before commencing.
k) On completion of your research, please forward any recommendations/findings that can be beneficial to use to take further action that may inform redevelopment of future policy / review guidelines.
l) Please contact Michelle Riley (Patient Fees) at ext. 2276 to ascertain if there will be charges for conducting the Research and to obtain a quote or to discuss charges
**m) Kindly submit a copy of the publication or report to this office on completion of the research.**
**n) At no time should any posters encouraging patients to partake in research, be displayed within a clinical area.**
**o) Please adhere to ALL COVID-19 regulations and Groote Schuur Hospital policies.**

I would like to wish you every success with the project.

Yours sincerely

Signed by candidate

**DR BERNADETTE EICK**
**CHIEF OPERATIONAL OFFICER**
**Date:** 6 August 2021

C.C. Mr. L. Naidoo / Dr T. Numanoglu / Mr A. Mohamed / Professor D. Stein

G46 Management Suite, Old Main Building,
Observatory 7925
Tel: +27 21 404 6288 fax: +27 21 404 6125

Private Bag X,
Observatory, 7935
www.westerncape.gov.za/health

## Appendix V: Submission Guidelines for the South African Journal of Psychiatry

Original Research Article

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An original article provides an overview of innovative research in a particular field within or related to the focus and scope of the journal, presented according to a clear and well-structured format. Systematic reviews should follow the same basic structure as other original research articles. The aim and objectives should focus on a clinical question that will be addressed in the review. The methods section should describe in detail the search strategy, criteria used to select or reject articles, attempts made to obtain all important and relevant studies and deal with publication bias (including grey and unpublished literature), and how the quality of included studies was appraised, the methodology used to extract and/or analyse data. Results should describe the homogeneity of the different findings, and clearly present the overall results and any meta-analysis.

| | |
|---|---|
| Submission status | open |
| Word limit | 3000-4000 words (excluding the abstract, tables, figures, graphs, and references) |
| Abstract | maximum: 250 words<br>requires structural headings: Background, Aim, Setting, Methods, Results, Conclusion and Contribution |
| Main text | requires structural headings, refer to the full structure<br>'Ethical considerations' is a sub-section in the manuscript and must include:<br>• Name of the ethical review committee<br>• Study approval number |

| | |
|---|---|
| | • Manner of consent (written, oral) for human participants<br>• Description of measures taken to maintain the confidentiality of data<br>• If the study was not human or animal research or the study was determined to be non-human subjects research or exempt, the authors must provide a statement with those details in this section. |
| References | 60 or less, adhere to the **Vancouver referencing style** |
| Tables, figures and graphs | 7 or less, adhere to the Illustrations requirements found in the AOSIS House style guide |
| Formatting requirements | apply the guidelines located on the **Formatting requirements page** and the **AOSIS house style guide** |
| Compulsory supplementary file(s) | the **Authorship, disclosure statements, copyright, and license agreement form**, **Ethical Clearance/Waiver Documentation** and any other relevant form applicable to your submission |
| **Ethical clearance/waiver documentation** | evidence of ethical clearance for the study, such as the study approval letter or certificate from the Institutional Review Board (IRB), a waiver from the IRB et cetera |

Original Research Article full structure

---

**Title:** The article's full title should contain a maximum of 95 characters (including spaces).

**Abstract:** The abstract, written in English, should be no longer than 250 words and must be written in the past tense. The abstract should give a succinct account of the objectives, methods, results and significance of the matter. The structured abstract for an Original Research article should consist of seven paragraphs labelled Background, Aim, Setting, Methods, Results, Conclusion and Contribution.

- Background: Summarise the social value (importance, relevance) and scientific value (knowledge gap) that your study addresses.
- Aim: State the overall aim of the study.
- Setting: State the setting for the study.
- Methods: Clearly express the basic design of the study, and name or briefly describe the methods used without going into excessive detail.
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